Balance Gold HRA PCP

Washington plans for groups 1-50
Beginning January 1, 2015

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

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

PCY = per calendar year

			BALANCE GOLD HRA	
			Heritage Signature providers	Non-Heritage Signature providers
	Individual Deductible	PCY (choose one) Family = 2x Individual deductible (in-network only)	$2,000	2x Individual
	Required Employer Contribution	Family = 2x employer contribution	$1,000	2x Individual
	Coinsurance	Amount you pay after your deductible is met	20%	50%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x Individual out-of-pocket max (in-network only)	$6,350	Unlimited
	Office visits	Designated PCP office visit Non-designated PCP or specialist office visit	$15 $45	50%
	Network		Heritage Signature	~
	10 Essential Benefits *Covered Services*			
1	**Ambulatory Patient Services**	Outpatient	20%	50%
		Spinal manipulation (10 visits PCY); Acupuncture (12 visits PCY)	$15	
2	**Emergency Services** *Includes ambulance*	Copay waived if directly admitted to an inpatient facility	$250 copay, then 20%	
3	**Hospitalization**	Inpatient services	20%	50%
		Organ and tissue transplants, inpatient unlimited, except $5,000 travel and lodging per transplant		Not covered
		Hospice: unlimited Respite care: 14 days per lifetime		50%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20%	50%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	$45	50%
		Inpatient hospital: mental/behavioral health	20%	
		Outpatient services	20%	
6	**Prescription Drugs**	**Retail** 30-day supply **Mail Order** 90-day supply (copay x 3) **Specialty Rx** 30-day supply **Drug Formulary** X3 formulary	Generic: $15 Brand: $50 Specialty: Deductible waived, then 20%	Not covered
7	**Rehabilitative & Habilitative Services & Devices** *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY	20%	50%
		Physical, speech, occupational, massage therapy: 25 visits PCY		
		Durable medical equipment		
		Skilled nursing facility: 60 days PCY		
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, CT, MRI, PET	20%	50%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings	Covered in full	50%
		Exams and immunizations		Not covered
10	**Pediatric Services** *Vision and Oral Care* *Under 19 years of age*	**Eye exam:** 1 PCY	$45	
		Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	
		Dental: preventive/basic/major	Coverd in full / 20% / 50%	30% / 40% / 50%
		Orthodontia (medically necessary only)	50%	

A full list of services is available on **premera.com/wa/member**

Definitions

Allowable charge:* The negotiated amount for which a contracted provider agrees to provide services 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.

Network: A group of doctors, dentists, hospitals, and other healthcare providers that contract with Premera to provide services and supplies at negotiated amounts called allowable charges.

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.

Producer: Previously referred to as a broker or agent.

Primary care provider (PCP): 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 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.

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 **800-722-5561** from 8 a.m. to 5 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 privacy policies, provider organization, key utilization management procedures, and pharmaceutical management procedures.

*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.

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
- 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**.