PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

2016 PPO 70% PLAN 1500

HERITAGE PRIME NETWORK

Effective Date: 10/01/2016

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	2016 PPO 70% PLAN 1500	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$1,500 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,000 PCY	Shared with In-Network
Office Visit Cost Share	$40 Copay, applies to the Out Of Pocket Maximum	Out of Network Deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
Immunizations (Unlimited)	Covered In Full	Dep Child to Age 18 Covered In Full; Members Over 18 Out of Network Deductible, then 50%
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	$40 Copay, applies to the Out Of Pocket Maximum	Out of Network Deductible, then 50%
Inpatient Professional Services	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Other Professional Diagnostic Imaging	First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Other Professional Diagnostic Laboratory/Pathology	First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Diagnostic Mammography	First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Outpatient Surgery Facility	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30%	$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30%
Emergency Room Physician	In Network Deductible, then 30%	In Network Deductible, then 30%
Ambulance Transportation (Unlimited)	In Network Deductible, then 30%	In Network Deductible, then 30%
Air Ambulance (Unlimited)	In Network Deductible, then 30%	In Network Deductible, then 30%

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	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Mental Health Outpatient Professional Care (Unlimited)	$40 Copay, applies to the Out Of Pocket Maximum	Out of Network Deductible, then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	$40 Copay, applies to the Out Of Pocket Maximum	Out of Network Deductible, then 50%
Rehab Inpatient Facility (30 Days PCY)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (25 Visits PCY)	$40 Copay, applies to the Out Of Pocket Maximum	Out of Network Deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer	$40 Copay, applies to the Out Of Pocket Maximum	Out of Network Deductible, then 50%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited; ME: Unlimited; Pro: Unlimited)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Home Health Visits (130 visits PCY)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))	Covered as any other service	Covered as any other service
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
Acupuncture (12 visits PCY)	In Network Deductible, then 30%	Out of Network Deductible, then 50%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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.

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 highligh is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

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Pharmacy Benefits

Tier 1 = Generic
Tier 2 = Preferred Brand Name
Tier 3 = Non Preferred Brand Name

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see our Preferred Drug List at www.premera.com.

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PHARMACY PLAN	**2016 PPO 70% PLAN 1500 - RX**
	Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS	
Retail Cost Shares	$10/$50/$80
Mail Cost Shares	$30/$150/$240
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY	$0
Out of Network (Non-participating retail pharmacies)	Retail Pharmacy & Preventive Generic Drug List Same as INN; OON Mail Order Not Covered
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited
Drug List	Preferred B3

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