PREMERA BLUE CROSS

Highlights of your Health Care Coverage

2016 HSA 1500

HERITAGE PLUS 1 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 HSA 1500	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$1,500 PCY/$3,000 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,000 PCY	Shared with In-Network
Office Visit Cost Share	In Network Deductible, then 20%	Out of Network Deductible, then 40%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered In Full	Waive Deductible, then 40%
Immunizations (Unlimited)	Covered In Full	Waive Deductible, then 40%
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Waive Deductible,then 40%
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Out of Network Deductible, then 40%
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Inpatient Professional Services	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible, then 40%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Waive Deductible, then 40%
Other Professional Diagnostic Imaging	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Diagnostic Mammography	In Network Deductible, then 20%	Out of Network Deductible, then 40%
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Outpatient Surgery Facility	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
Emergency Care	In Network Deductible, then 20%	In Network Deductible, then 20%
Emergency Room Physician	In Network Deductible, then 20%	In Network Deductible, then 20%
Ambulance Transportation (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Air Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%

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MEDICAL PLAN	2016 HSA 1500	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Rehab Inpatient Facility (30 Days PCY)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (25 Visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited; ME: Unlimited; Pro: Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Home Health Visits (130 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Hospice Care (Hospice Home Visits: Unlimited; Respite 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
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
Prescription Drugs - Retail (generic/preferred/non-preferred) (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	In Network Deductible, then 20%	In Network Deductible, then 20%
Prescription Drugs - Mail (generic/preferred/non-preferred) (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	In Network Deductible, then 20%	In Network Deductible, then 20%
Specialty Pharmacy (Mandatory)	In Network Deductible, then 20%	Not Covered
Drug List	Open A1	Open A1
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
Acupuncture (12 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then 40%
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.