

Who are you healthy for?

Be there for the people you care about

Health plans
for individuals
and families

1/1/2016





**WE'RE HERE FOR YOU
EVERY STEP OF THE WAY**

For help choosing
and enrolling in a plan

877-PREmera
(877-773-6372)

shop.premera.com

We have a plan to fit you and your family

Premera Blue Cross has a health plan that's right for you and your family, matched to your health needs, family size, stage of life, and financial situation. Our wide range of plans offers you the price, the choice of doctors, pharmacies, and hospitals, and the benefits you need so you can be there for the people and activities you care about.

We're here to walk you through the process of choosing and enrolling in a plan, making sure you understand all your options and what you're getting. We can help you figure out if you're eligible for help paying for your plan—a subsidy—and enroll you through Washington Healthplanfinder if you are.

The whole process can be as simple as one phone conversation. But of course we're also happy to give you all the time you need to make the right choice.

Welcome to Premera Blue Cross.

For more than 80 years, Washington families have trusted Premera for their health coverage. Today, we cover more than 2 million people. We are dedicated to being there for you at every stage of your life, so you can be there for the people most important to you.

We have plans for every need and budget, and we are ready to help you understand your options every step of the way.

Thank you for considering Premera. We welcome the opportunity to be your health plan.



Jim Havens

Vice President & General Manager
Individual & Senior Markets

Consider these factors when choosing a health plan



FIND A DOCTOR

If you already have a doctor or go to certain pharmacies or hospitals, check to see if they are in the Heritage Signature provider network if you're considering a PPO plan, or the Partner System for a PersonalCare plan. Then search for the provider by using the Find a Doctor tool on premera.com.



CHECK YOUR MEDICATION COVERAGE

If you take prescription medications, check coverage at premera.com. Select Pharmacy, then click Rx Search. (See the plan summary for the name of the drug formulary (such as X1) to check prescription coverage for the appropriate plan.) Your share of the cost for prescriptions varies depending on whether the medication is a generic, brand-name, or specialty drug.

Which doctors you can see

The provider network

The network includes doctors, pharmacies, hospitals, and other care providers. You'll almost always pay less if you use providers that are in your plan's network.

Our PPO plans have the largest network—statewide, nationwide, and beyond. Our PersonalCare plans include five leading medical systems in King, Snohomish, and Pierce counties.

What you get for your money

The benefits

Our plans cover recommended preventive care services at no cost to you, plus office visits, urgent and emergency care, prescription drugs, lab tests, maternity and newborn care, hospitalization, mental health care, and more.

For more detailed information about benefits, call **877-PREMER**A or visit premera.com.



ALTERNATIVE
CARE



DIET AND NUTRITION
PRODUCTS



SEATTLE FITNESS
CLUB MEMBERSHIPS

In addition to the essential benefits, all Premera medical plans include discounts on other health options that you might like.

How much it costs you

Monthly premiums and cost shares

Premiums are due monthly, similar to your car or home insurance.

When you see a doctor or get other medical care, you pay a share of the cost, and your health plan pays the rest. Your share includes deductibles, copays (a fixed charge), and coinsurance (a percentage of the cost).

Another important cost to pay attention to is your out-of-pocket maximum—the most you'll pay in a year for covered healthcare services.

For more details about these terms, see page 17.

Premera plans are available at different levels—bronze, silver, and gold—so you can pick the one that meets your needs. These levels refer only to the costs of the plans, not the quality. In most cases, they cover the same benefits.



YOU MAY BE ELIGIBLE FOR A SUBSIDY

Depending on your household income, you may be eligible for a tax credit, also known as a subsidy, to help pay for your health coverage. In Washington, as many as half of the individuals enrolling in health plans are eligible for subsidies.

We can help you find out if you qualify for a subsidy and apply through Washington Healthplanfinder. Call 877-PREmera.



REMEMBER

The plan with the lowest monthly premium may not always be the lowest-cost choice for you. Which plan is best for you depends on whether you expect to need a lot of medical services during the year, or whether you are in excellent health and need coverage just in case something happens.

	GOLD PLANS	SILVER PLANS	BRONZE PLANS
Plan generally covers this percentage of your healthcare costs	80%	70%	60%
Monthly premiums	Higher	Medium	Lower
Your share of costs for medical care (deductible, copay, coinsurance)	Lower	Medium	Higher
Out-of-pocket maximum	Lower	Medium	Higher
Good fit if you...	Expect to need care frequently	May need care sometimes	Are healthy and expect to need little care

Choose the Premera plan that's right for you



FOR MORE INFORMATION

For help selecting a plan and enrolling, call **877-PREmera** or visit **shop.premera.com**.

Premera offers several different plans, available at different cost levels—bronze, silver and gold. You can see details for each plan on **premiera.com**.

Before you choose, decide which type of plan is best for you:

- Most common are preferred provider organization (PPO) plans—available statewide, except in Clark County.
- New for 2016 are PersonalCare plans, available in King, Snohomish, and Pierce counties.

There are two main differences between PPO plans and PersonalCare plans:



VIRTUAL CARE

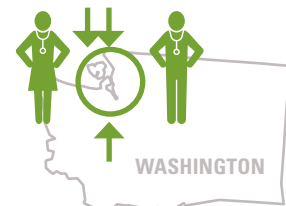
Most of our plans offer access to virtual care, so you can consult with a doctor anytime by phone or online video—usually for the same cost as an in-person office visit. All of our plans include access to the free 24-Hour NurseLine for advice anytime day or night.



PREFERRED PROVIDER ORGANIZATION

National Network

PPO plans have a large state and nationwide network of providers. You can seek care from any of these providers without referrals.



PERSONALCARE PLANS

King, Snohomish, Pierce Counties

PersonalCare plans coordinate seamless local support through your selected primary care doctor, and within a PersonalCare Partner System.

With both PPO and PersonalCare plans, you can choose from a wide variety of primary care providers, ob/gyn's, pediatricians, nurse practitioners, and physician's assistants. With PPO plans, you can also choose a naturopath as your doctor.

Preferred Provider Organization (PPO) plans

PPOs are the most common type of plan. They give you the greatest choice and flexibility of doctors and other providers, both locally and when you travel.

If you see providers in the network, you'll pay less—but you can also see out-of-network providers and we'll still pay part of the cost. And you don't need referrals to see specialists.

PPO plans include access to the national and worldwide Blue Cross Blue Shield BlueCard™ network of providers at in-network costs to you. You can find the same quality of care you expect from Premiera just about anywhere.



PPO plans come in two different designs. You'll see these terms in the plan names:

Preferred Plans

Most gold and silver level plans include two visits to your primary care doctor at no cost to you. And after that you'll have unlimited primary care office visits for only a copay, with no deductible. In addition, when you select a primary care doctor, your office visit copays will be lower. (Exception: HSA plans, which don't use copays.)

Health Savings Account (HSA) Plans

These are qualified high-deductible PPO plans paired with a health savings account. These plans allow you to set up accounts to save and invest your money for future healthcare. They also have certain tax advantages. These plans generally have lower premiums, but you usually pay your share upfront.



PersonalCare Plans (King, Snohomish, and Pierce counties)

These plans, new for 2016, offer you affordable and coordinated healthcare from an integrated, local community of leading providers, called PersonalCare Partner Systems.

Choices for care

When you choose your plan, you also choose one of our partner systems and a primary care doctor in that system, for a central point of care. Each member of your family can choose a different partner system and a different doctor, and you are free to change your system or doctor at almost any time.

Costs

Monthly premiums for these plans are lower than PPO plans with similar benefits. And for most services you pay only a fixed copay, so your out-of-pocket costs are more predictable.

These plans help keep healthcare affordable because our partner systems provide and coordinate all of your care. In addition, they are paid based on the quality of the care, the care experience they provide and whether they improve your health.

Referrals and out-of-area coverage

If you need to see a specialist, your primary care doctor will refer you to one in your partner system, or in our statewide Heritage Signature network if needed.

These plans include coverage outside your partner system in cases of emergency. If you need non-emergent care while traveling in Washington, your doctor can make a referral in our statewide Heritage Signature network.

PERSONALCARE PARTNER SYSTEM	SERVICE AREA
EvergreenHealth	East King County and southeast Snohomish County
MultiCare	Pierce County and south King County
Northwest Physicians Network	Pierce County and south King County
UW Medicine	King County, south Snohomish County, north Pierce County
Virginia Mason	King County and south Snohomish County

Consider dental coverage

Get high-quality dental coverage at a great value from the same company you already trust for your medical coverage.



WHY DENTAL HEALTH IS IMPORTANT

Dental and oral health can offer clues about your overall health, and problems in your mouth can affect the rest of your body.

For details about dental coverage, visit premera.com, click Shop for Plans, and select Dental Plans.

Adult Dental Coverage

Our Adult Dental Plan gives you coverage for a wide range of preventive and diagnostic, basic, and major dental services. It's easy and seamless to add this coverage when you enroll in a medical plan, or any time during the year.

With all your medical and dental coverage from one company, you get the convenience of one monthly premium bill, one ID card, and one Customer Service number. You can access all your coverage documents and claims records from one website and one mobile app.

Pediatric Dental Coverage

If your medical plan will cover dependents 18 or younger, federal law requires you to purchase a pediatric dental plan, either from Premera or another company, at the same time. This coverage is not required if you don't cover any children.

The Premera Individual Pediatric Dental Plan provides:

- Coverage for most preventive and diagnostic, basic, and major dental services
- Access to a network of dentists throughout Washington
- No waiting period for dental services—your child can see a dentist immediately after the effective date of your plan

STEP

4

Let us help you enroll now



WHAT YOU'LL NEED BEFORE YOU CALL

When you call, be sure you have names, birth dates, and Social Security numbers for all family members you want to enroll, and household income to determine if you qualify for a subsidy.

We want to help you choose the right plan for yourself and your family, with the coverage you need at a price that fits your budget. We can help you find out whether you qualify for a subsidy to help pay for your health plan.

Take this last important step so you can be there for the people you care about.

Contact us today.

For detailed information about coverage and costs and help enrolling:



Call 877-PREMER (877-773-6372)
8 a.m. – 5 p.m. Pacific time Monday–Friday



Visit shop.premera.com



Call or visit your producer

PREFERRED GOLD 1000

Washington plan for individuals & families

Beginning January 1, 2016

		PREFERRED GOLD 1000	
		Heritage Signature provider network	Non-Heritage Signature provider network
Annual Deductible	Per Calendar Year (PCY) Family = 2x individual (<i>in-network</i>)	\$1,000	2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	50%
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (<i>in-network</i>)	\$4,500	Unlimited
10 Essential Benefits Covered Services			
1 Ambulatory Patient Services	Outpatient services	Deductible, then 20%	Deductible, then 50%
Office Visits	Designated PCP office visit	\$10 copay, first 2 PCP visits covered in full	Deductible, then 50%
	Non-designated PCP & specialist office visit	\$30 copay	Deductible, then 50%
	Urgent care	\$30 copay	Deductible, then 50%
	Virtual care	\$10 copay	Not covered
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	\$10 copay	Deductible, then 50%
2 Emergency Services	Emergency care (<i>copay waived if directly admitted to an inpatient facility</i>)	\$200 copay, then deductible, then 20%	Same as in-network
	Ambulance	Deductible, then 20%	Same as in-network
3 Hospitalization	Inpatient services	Deductible, then 20%	Deductible, then 50%
	Organ and tissue transplants, inpatient	Deductible, then 20%	Not covered
4 Maternity & Newborn Care	Prenatal and postnatal care	Deductible, then 20%	Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	\$30 copay	Deductible, then 50%
	Inpatient hospital: mental/behavioral health	Deductible, then 20%	Deductible, then 50%
	Outpatient services	Deductible waived, then 20%	Deductible, then 50%
6 Prescription Drugs	Generic	\$10 copay	Not covered
<i>Retail/Specialty: 30-day supply</i>	Brand	\$30 copay	Not covered
<i>Mail Order: 90-day supply</i>	Specialty	Deductible, then 20%	Not covered
<i>(copay x3)</i>	Drug formulary	X3	
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	Deductible, then 20%	Deductible, then 50%
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	Deductible, then 20%	Deductible, then 50%
	Durable medical equipment	Deductible, then 20%	Deductible, then 50%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	Deductible waived, then 20%	Deductible, then 50%
	Major imaging including MRI, CT, PET (<i>prior authorization required for certain services</i>)	Deductible, then 20%	Deductible, then 50%
9 Preventive/Wellness Services	Screenings	Covered in full	Deductible, then 50%
	Exams and immunizations	Covered in full	Not covered
10 Pediatric Vision	Eye exam: 1 PCY	\$30 copay	Same as in-network
<i>Under 19 years of age</i>	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network

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PREFERRED SILVER 3000

Washington plan for individuals & families
Beginning January 1, 2016

		PREFERRED SILVER 3000	
		Heritage Signature provider network	Non-Heritage Signature provider network
Annual Deductible	Per Calendar Year (PCY) Family = 2x individual (<i>in-network</i>)	\$3,000	2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	50%
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (<i>in-network</i>)	\$6,850	Unlimited
10 Essential Benefits Covered Services			
1 Ambulatory Patient Services	Outpatient services	Deductible, then 20%	Deductible, then 50%
Office Visits	Designated PCP office visit	\$15 copay, first 2 PCP visits covered in full	Deductible, then 50%
	Non-designated PCP & specialist office visit	\$50 copay	Deductible, then 50%
	Urgent care	\$50 copay	Deductible, then 50%
	Virtual care	\$15 copay	Not covered
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	\$15 copay	Deductible, then 50%
2 Emergency Services	Emergency care (<i>copay waived if directly admitted to an inpatient facility</i>)	\$250 copay, then deductible, then 20%	Same as in-network
	Ambulance	Deductible, then 20%	Same as in-network
3 Hospitalization	Inpatient services	Deductible, then 20%	Deductible, then 50%
	Organ and tissue transplants, inpatient	Deductible, then 20%	Not covered
4 Maternity & Newborn Care	Prenatal and postnatal care	Deductible, then 20%	Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	\$50 copay	Deductible, then 50%
	Inpatient hospital: mental/behavioral health	Deductible, then 20%	Deductible, then 50%
	Outpatient services	Deductible waived, then 20%	Deductible, then 50%
6 Prescription Drugs	Generic	\$20	Not covered
<i>Retail/Specialty: 30-day supply</i>	Brand	\$55 copay	Not covered
<i>Mail Order: 90-day supply</i>	Specialty	Deductible, then 20%	Not covered
<i>(copay x3)</i>	Drug formulary	X3	
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	Deductible, then 20%	Deductible, then 50%
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	Deductible, then 20%	Deductible, then 50%
	Durable medical equipment	Deductible, then 20%	Deductible, then 50%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	Deductible waived, then 20%	Deductible, then 50%
	Major imaging including MRI, CT, PET (<i>prior authorization required for certain services</i>)	Deductible, then 20%	Deductible, then 50%
9 Preventive/Wellness Services	Screenings	Covered in full	Deductible, then 50%
	Exams and immunizations	Covered in full	Not covered
10 Pediatric Vision	Eye exam: 1 PCY	\$45 copay	Same as in-network
<i>Under 19 years of age</i>	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network

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PREFERRED BRONZE 6350

Washington plan for individuals & families

Beginning January 1, 2016

		PREFERRED BRONZE 6350	
		Heritage Signature provider network	Non-Heritage Signature provider network
Annual Deductible	Per Calendar Year (PCY) Family = 2x individual (<i>in-network</i>)	\$6,350	2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	50%
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (<i>in-network</i>)	\$6,850	Unlimited
10 Essential Benefits Covered Services			
1 Ambulatory Patient Services	Outpatient services	Deductible, then 20%	Deductible, then 50%
Office Visits	Designated PCP office visit	\$20 copay	Deductible, then 50%
	Non-designated PCP & specialist office visit	Deductible, then 20%	Deductible, then 50%
	Urgent care	Deductible, then 20%	Deductible, then 50%
	Virtual care	\$20 copay	Not covered
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	\$20 copay	Deductible, then 50%
2 Emergency Services	Emergency care (<i>copay waived if directly admitted to an inpatient facility</i>)	\$250 copay, then deductible, then 20%	Same as in-network
	Ambulance	Deductible, then 20%	Same as in-network
3 Hospitalization	Inpatient services	Deductible, then 20%	Deductible, then 50%
	Organ and tissue transplants, inpatient	Deductible, then 20%	Not covered
4 Maternity & Newborn Care	Prenatal and postnatal care	Deductible, then 20%	Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	Deductible, then 20%	Deductible, then 50%
	Inpatient hospital: mental/behavioral health	Deductible, then 20%	Deductible, then 50%
	Outpatient services	Deductible, then 20%	Deductible, then 50%
6 Prescription Drugs	Generic	Deductible, then 20%	Not covered
<i>Retail/Specialty: 30-day supply</i>	Brand	Deductible, then 20%	Not covered
<i>Mail Order: 90-day supply</i>	Specialty	Deductible, then 20%	Not covered
	Drug formulary	X1	
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	Deductible, then 20%	Deductible, then 50%
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	Deductible, then 20%	Deductible, then 50%
	Durable medical equipment	Deductible, then 20%	Deductible, then 50%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	Deductible, then 20%	Deductible, then 50%
	Major imaging including MRI, CT, PET (<i>prior authorization required for certain services</i>)	Deductible, then 20%	Deductible, then 50%
9 Preventive/Wellness Services	Screenings	Covered in full	Deductible, then 50%
	Exams and immunizations	Covered in full	Not covered
10 Pediatric Vision	Eye exam: 1 PCY	\$30 copay	Same as in-network
<i>Under 19 years of age</i>	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network

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PERSONALCARE GOLD 750

Washington plan for individuals & families

Beginning January 1, 2016

PersonalCare Plans are a new way for you to receive more coordinated care and coverage in King, Pierce and Snohomish counties. Each member chooses their own PersonalCare Partner system and personal doctor (PCP) in that system who gives, or refers you for the care you need. Note that the plans cover only emergency services outside your Partner system.

PERSONALCARE GOLD 750

PersonalCare Partner System

Annual Deductible	Per Calendar Year (PCY) Family = 2x individual (<i>in-network only</i>)	\$750
Coinsurance	Amount you pay after your deductible is met	20% coinsurance
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (<i>in-network only</i>)	\$4,500
10 Essential Benefits Covered Services		
1 Ambulatory Patient Services	Outpatient services	Deductible, then 20%
Office Visits	Designated PCP office visit	\$15 copay
	Specialist office visit	\$40 copay
	Urgent care	\$40 copay
	Virtual care	\$15 copay
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	\$15 copay
2 Emergency Services	Emergency care (<i>copay waived if directly admitted to an inpatient facility</i>)	\$200 copay
	Ambulance	\$200 copay
3 Hospitalization	Inpatient services	\$500 copay per day (maximum of 3 copays per admission), then deductible
	Organ and tissue transplants, inpatient	\$500 copay per day (maximum of 3 copays per admission), then deductible
4 Maternity & Newborn Care	Prenatal and postnatal care	\$15 copay
	Inpatient delivery and services	\$500 copay per day (maximum of 3 copays per admission), then deductible
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	\$40 copay
	Inpatient hospital: mental/behavioral health	\$500 copay per day (maximum of 3 copays per admission), then deductible
	Outpatient services	Deductible, then 20%
6 Prescription Drugs	Generic	\$10
<i>Retail/Specialty: 30-day supply</i>	Preferred brand	\$40
<i>Mail Order: 90-day supply</i>	Non-preferred brand	\$80
<i>(copay x3)</i>	Specialty	\$100
	Drug formulary	X4
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	\$500 copay per day (maximum of 3 copays per admission), then deductible
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	\$40 copay
	Durable medical equipment	Deductible, then 20%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	\$50 copay
	Major imaging including MRI, CT, PET (<i>prior authorization required for certain services</i>)	\$250 copay
9 Preventive/Wellness Services	Screenings	Covered in full
	Exams and immunizations	Covered in full
10 Pediatric Vision	Eye exam: 1 PCY	\$30 copay
<i>Under 19 years of age</i>	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full

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PERSONALCARE SILVER 2500

Washington plan for individuals & families

Beginning January 1, 2016

PersonalCare Plans are a new way for you to receive more coordinated care and coverage in King, Pierce and Snohomish counties. Each member chooses their own PersonalCare Partner system and personal doctor (PCP) in that system who gives, or refers you for the care you need. Note that the plans cover only emergency services outside your Partner system.

PERSONALCARE SILVER 2500		
PersonalCare Partner System		
Annual Deductible	Per Calendar Year (PCY) Family = 2x individual (<i>in-network only</i>)	\$2,500
Coinsurance	Amount you pay after your deductible is met	20% coinsurance
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (<i>in-network only</i>)	\$6,850
10 Essential Benefits Covered Services		
1 Ambulatory Patient Services	Outpatient services	Deductible, then 20%
Office Visits	Designated PCP office visit	\$20 copay
	Specialist office visit	\$45 copay
	Urgent care	\$45 copay
	Virtual care	\$20 copay
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	\$20 copay
2 Emergency Services	Emergency care (<i>copay waived if directly admitted to an inpatient facility</i>)	\$250 copay, then deductible
	Ambulance	\$250 copay
3 Hospitalization	Inpatient services	\$600 copay per day (maximum of 4 copays per admission), then deductible
	Organ and tissue transplants, inpatient	\$600 copay per day (maximum of 4 copays per admission), then deductible
4 Maternity & Newborn Care	Prenatal and postnatal care	\$20 copay
	Inpatient delivery and services	\$600 copay per day (maximum of 4 copays per admission), then deductible
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	\$45 copay
	Inpatient hospital: mental/behavioral health	\$600 copay per day (maximum of 4 copays per admission), then deductible
	Outpatient services	Deductible, then 20%
6 Prescription Drugs	Generic	\$15
<i>Retail/Specialty: 30-day supply</i>	Preferred brand	\$50
<i>Mail Order: 90-day supply</i>	Non-preferred brand	\$100
<i>(copay x3)</i>	Specialty	Deductible, then \$150
	Drug formulary	X4
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	\$600 copay per day (maximum of 4 copays per admission), then deductible
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	\$45 copay
	Durable medical equipment	Deductible, then 20%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	\$100 copay
	Major imaging including MRI, CT, PET (<i>prior authorization required for certain services</i>)	\$500 copay, then deductible
9 Preventive/Wellness Services	Screenings	Covered in full
	Exams and immunizations	Covered in full
10 Pediatric Vision	Eye exam: 1 PCY	\$30 copay
<i>Under 19 years of age</i>	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full

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PERSONALCARE BRONZE 4500

Washington plan for individuals & families

Beginning January 1, 2016

PersonalCare Plans are a new way for you to receive more coordinated care and coverage in King, Pierce and Snohomish counties. Each member chooses their own PersonalCare Partner system and personal doctor (PCP) in that system who gives, or refers you for the care you need. Note that the plans cover only emergency services outside your Partner system.

PERSONALCARE BRONZE 4500

PersonalCare Partner System

\$4,500 Medical \$1,000 Prescription

Annual Deductible Per Calendar Year (PCY)
Family = 2x individual (*in-network only*)

Coinsurance Amount you pay after your deductible is met

25% coinsurance

Out-of-Pocket Maximum Includes deductible, coinsurance, and copays
Family = 2x individual (*in-network only*)

\$6,850

10 Essential Benefits Covered Services

1 Ambulatory Patient Services Office Visits	Outpatient services	Deductible, then 25%
	Designated PCP office visit	\$30 copay
	Specialist office visit	\$50 copay, then deductible
	Urgent care	\$50 copay, then deductible
	Virtual care	\$30 copay
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	\$30 copay
2 Emergency Services	Emergency care (<i>copay waived if directly admitted to an inpatient facility</i>)	\$250 copay, then deductible
	Ambulance	\$250 copay
3 Hospitalization	Inpatient services	\$700 copay per day (maximum of 5 copays per admission), then deductible
	Organ and tissue transplants, inpatient	\$700 copay per day (maximum of 5 copays per admission), then deductible
4 Maternity & Newborn Care	Prenatal and postnatal care	\$30 copay
	Inpatient delivery and services	\$700 copay per day (maximum of 5 copays per admission), then deductible
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	\$50 copay, then deductible
	Inpatient hospital: mental/behavioral health	\$700 copay per day (maximum of 5 copays per admission), then deductible
	Outpatient services	Deductible, then 25%
6 Prescription Drugs <i>Retail/Specialty: 30-day supply</i> <i>Mail Order: 90-day supply</i> <i>(copay x3)</i>	Generic	\$25 copay, no prescription deductible
	Preferred brand	Prescription deductible, then \$65 copay
	Non-preferred brand	Prescription deductible, then \$150 copay
	Specialty	Prescription deductible, then \$250 copay
	Drug formulary	X4
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	\$700 copay per day (maximum of 5 copays per admission), then deductible
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	\$50 copay, then deductible
	Durable medical equipment	Deductible, then 25%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	\$100 copay, then deductible
	Major imaging including MRI, CT, PET (<i>prior authorization required for certain services</i>)	\$750 copay, then deductible
9 Preventive/Wellness Services	Screenings	Covered in full
	Exams and immunizations	Covered in full
10 Pediatric Vision <i>Under 19 years of age</i>	Eye exam: 1 PCY	\$30 copay
	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts	Covered in full
	PCY, in lieu of glasses (frames & lenses)	

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PREFERRED SILVER 3000 HSA

Washington plan for individuals & families

Beginning January 1, 2016

		PREFERRED SILVER 3000 HSA	
		Heritage Signature provider network	Non-Heritage Signature provider network
Annual Deductible	Per Calendar Year (PCY) Family = 2x individual	\$3,000	2x Individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	50%
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (<i>in-network</i>)	\$4,100	Unlimited
10 Essential Benefits Covered Services			
1 Ambulatory Patient Services	Outpatient services	Deductible, then 20%	Deductible, then 50%
Office Visits	PCP office visit	Deductible, then 20%	Deductible, then 50%
	Non-designated PCP & specialist office visit	Deductible, then 20%	Deductible, then 50%
	Urgent care	Deductible, then 20%	Deductible, then 50%
	Virtual care	Deductible, then 20%	Deductible, then 50%
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	Deductible, then 20%	Deductible, then 50%
2 Emergency Services	Emergency care	Deductible, then 20%	Same as in-network
	Ambulance	Deductible, then 20%	Same as in-network
3 Hospitalization	Inpatient services	Deductible, then 20%	Deductible, then 50%
	Organ and tissue transplants, inpatient	Deductible, then 20%	Not covered
4 Maternity & Newborn Care	Prenatal and postnatal care	Deductible, then 20%	Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	Deductible, then 20%	Deductible, then 50%
	Inpatient hospital: mental/behavioral health	Deductible, then 20%	Deductible, then 50%
	Outpatient services	Deductible, then 20%	Deductible, then 50%
6 Prescription Drugs	Generic	Deductible, then 20%	Not covered
<i>Retail/Specialty: 30-day supply</i>	Brand	Deductible, then 20%	Not covered
<i>Mail Order: 90-day supply</i>	Specialty	Deductible, then 20%	Not covered
	Drug formulary	X1	
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	Deductible, then 20%	Deductible, then 50%
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	Deductible, then 20%	Deductible, then 50%
	Durable medical equipment	Deductible, then 20%	Deductible, then 50%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	Deductible, then 20%	Deductible, then 50%
	Major imaging including MRI, CT, PET (prior authorization required for certain services)	Deductible, then 20%	Deductible, then 50%
9 Preventive/Wellness Services	Screenings	Covered in full	Deductible, then 50%
	Exams and immunizations	Covered in full	Not covered
10 Pediatric Vision	Eye exam: 1 PCY	Deductible waived, then 20%	Same as in-network
<i>Under 19 years of age</i>	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network

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PREFERRED BRONZE 5250 HSA

Washington plan for individuals & families

Beginning January 1, 2016

		PREFERRED BRONZE 5250 HSA	
		Heritage Signature provider network	Non-Heritage Signature provider network
Annual Deductible	Per Calendar Year (PCY) Family = 2x individual	\$5,250	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 (<i>in-network</i>)	\$6,100	Unlimited
10 Essential Benefits Covered Services			
1 Ambulatory Patient Services Office Visits	Outpatient services	Deductible, then 20%	Deductible, then 50%
	PCP office visit	Deductible, then 20%	Deductible, then 50%
	Non-designated PCP & specialist office visit	Deductible, then 20%	Deductible, then 50%
	Urgent care	Deductible, then 20%	Deductible, then 50%
	Virtual care	Deductible, then 20%	Not covered
	Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	Deductible, then 20%	Deductible, then 50%
2 Emergency Services	Emergency care	Deductible, then 20%	Same as in-network
	Ambulance	Deductible, then 20%	Same as in-network
3 Hospitalization	Inpatient services	Deductible, then 20%	Deductible, then 50%
	Organ and tissue transplants, inpatient	Deductible, then 20%	Not covered
4 Maternity & Newborn Care	Prenatal and postnatal care	Deductible, then 20%	Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	Deductible, then 20%	Deductible, then 50%
	Inpatient hospital: mental/behavioral health	Deductible, then 20%	Deductible, then 50%
	Outpatient services	Deductible, then 20%	Deductible, then 50%
6 Prescription Drugs <i>Retail/Specialty: 30-day supply</i> <i>Mail Order: 90-day supply</i>	Generic	Deductible, then 20%	Not covered
	Brand	Deductible, then 20%	Not covered
	Specialty	Deductible, then 20%	Not covered
	Drug formulary	X1	
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY	Deductible, then 20%	Deductible, then 50%
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	Deductible, then 20%	Deductible, then 50%
	Durable medical equipment	Deductible, then 20%	Deductible, then 50%
8 Laboratory Services	Includes x-ray, pathology, imaging/diagnostic, ultrasound	Deductible, then 20%	Deductible, then 50%
	Major imaging including MRI, CT, PET (prior authorization required for certain services)	Deductible, then 20%	Deductible, then 50%
9 Preventive/Wellness Services	Screenings	Covered in full	Deductible, then 50%
	Exams and immunizations	Covered in full	Not covered
10 Pediatric Vision <i>Under 19 years of age</i>	Eye exam: 1 PCY	Deductible waived, then 20%	Same as in-network
	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network

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Exclusions and Limitations

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

Cosmetic surgery or reconstructive surgery (except as specifically provided)	Orthognathic surgery (except when repairing a dependent child’s congenital abnormality)	Services received when you are not covered by this program
Experimental or investigative services	Service in excess of specified benefit maximums	Sexual dysfunction
Infertility	Services payable by other types of insurance coverage	Sterilization reversal
Obesity/morbid obesity, including surgery, drugs, foods, and exercise programs		<i>For a list of services and procedures that require approval for coverage from your plan before you receive them (prior authorization), visit premera.com.</i>

Definitions of Healthcare Coverage Terms

<p>Allowed Amount — When providers have a contract with us, the amount your health plan has agreed to pay healthcare providers for services or supplies. You’ll be responsible only for any applicable cost sharing, including deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan. In-network providers cannot bill you for charges over the allowed amount.</p> <p>Coinurance — 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 pays the other 80% of the allowed amount.</p> <p>Copay — A flat fee you pay for a specific service, such as an office visit, at the time you receive service.</p>	<p>Covered In Full — Services for which your plan pays the total cost, at 100% of the allowed amount. You do not pay deductibles, coinsurance or copays for these services.</p> <p>Deductible — The amount of money you pay every year for covered services before the plan pays for certain benefits.</p> <p>Formulary — A list of drugs covered by a health plan. Not all generic, brand-name and specialty drugs are included in every formulary.</p> <p>Health Savings Account (HSA) — A savings account through a bank that is available to individuals who are enrolled in a qualified high-deductible health plan. The funds contributed to the account, as well as interest and investment earnings, aren’t subject to federal income tax when used for qualified medical expenses.</p>	<p>In-Network — Doctors, dentists, hospitals, and other healthcare providers that are contracted to provide services and supplies at negotiated amounts called allowed amounts.</p> <p>Out-of-Pocket Maximum — The maximum amount of money you will pay for covered services in a calendar year. After you’ve paid this amount, your plan pays 100% of the allowed amount for services received from in-network providers.</p>
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This is only a summary of the major benefits provided by our plans. This is not a contract. Please see [premera.com/SBC](https://www.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.



Premera Blue Cross health plans include tools to help you manage your health and your plan:

- **Cost and quality tool.** Estimate costs for services from various providers and view ratings and reviews from other customers.
- **Spending activity report.** Track your claims and the status of your deductible, among other things.
- **Find a Doctor.** Research providers and check which networks include them at premera.com or via Premera Mobile.
- **Premera Mobile.** Download the free app for on-the-go access to locate doctors, show proof of coverage, manage benefits, claims, and prescriptions — and more.

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and enrolling in a plan

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