# Summary of Benefits and Coverage: What this <u>Plan</u> Covers & What You Pay For Covered Services Premera Blue Cross : PPO 70% Plan 2000

Coverage for: Individual or Family | <u>Plan</u> Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-722-1471 (TTY: 711) or visit us at www.premera.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary/</u> or call 1-800-722-1471 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$2,000 Individual / \$4,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible?</u>	Yes. Does not apply to <u>Preventive</u> <u>care, copayments, prescription</u> <u>drugs</u> and services listed below as "No charge"	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$6,000 Individual / \$12,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>prior</u> <u>authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.premera.com or call 1-800-722-1471 for a list of <u>network</u> <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance</u> <u>billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What You Will PayNetwork ProviderOut-of-Network Provider(You will pay the least)(You will pay the most)		Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit	50% coinsurance	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	50% coinsurance	None
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive</u> <u>care/screening</u> / immunization	No charge	Preventative care: 50% coinsurance Immunization: No charge (under age 18), 50% coinsurance (18 and older)	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	First \$500 no charge, (shared with imaging), then 30% <u>coinsurance</u>	First \$500 no charge, (shared with imaging), then 50% <u>coinsurance</u>	None
lf you have a test	Imaging (CT/PET scans, MRIs)	First \$500 no charge, (shared with <u>diagnostic tests</u> ), then 30% <u>coinsurance</u>	First \$500 no charge, (shared with <u>diagnostic</u> <u>tests</u> ), then 50% <u>coinsurance</u>	Prior authorization required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
If you need drugs to treat your illness or condition	Generic drugs	\$10 <u>copay</u> /prescription (retail), \$30 <u>copay</u> /prescription (mail)	\$10 <u>copay</u> /prescription (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. <u>Prior authorization</u> required for some drugs.
More information about prescription drug coverage is available at	Preferred brand drugs	\$50 <u>copay</u> /prescription (retail), \$150 <u>copay</u> /prescription (mail)	\$50 <u>copav</u> /prescription (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). <u>Prior</u> <u>authorization</u> required for some drugs.
https://www.premera.co	Non-preferred brand drugs	\$80 <u>copay</u> /prescription (retail), \$240 <u>copay</u> /prescription (mail)	\$80 <u>copay</u> /prescription (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). <u>Prior</u> <u>authorization</u> required for some drugs.
m/documents/052147_2 024.pdf	Specialty drugs	\$250 <u>copay</u> /prescription	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior <u>authorization</u> required for some drugs.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	<u>Network Provider</u> (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.	
	Physician/surgeon fees	30% <u>coinsurance</u>	50% coinsurance	None	
	Emergency room care	\$200 <u>copay</u> /visit + 30% <u>coinsurance</u>	\$200 <u>copay</u> /visit + 30% <u>coinsurance</u>	Emergency room <u>copay</u> waived if admitted to hospital.	
If you need immediate	Emergency medical transportation	30% coinsurance	30% coinsurance	None	
medical attention	<u>Urgent care</u>	Hospital-based: \$200 <u>copay</u> /visit + 30% <u>coinsurance</u> Freestanding center: \$40 <u>copay</u> /visit	Hospital-based: \$200 <u>copay</u> /visit + 30% <u>coinsurance</u> Freestanding center: 50% <u>coinsurance</u>	None	
lf you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None	
lf you need mental health, behavioral	Outpatient services	Office Visit: \$40 <u>copay</u> /visit Facility: 30% <u>coinsurance</u>	50% coinsurance	None	
health, or substance abuse services	Inpatient services	30% <u>coinsurance</u>	50% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.	
	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventive	
lf you are pregnant	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	<u>services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	include tests and services described elsewhere in the SBC (such as, ultrasound).	

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	<u>Network Provider</u> (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Home health care	30% coinsurance	50% coinsurance	Limited to 130 visits per calendar year	
	Rehabilitation services	Outpatient: \$40 <u>copav</u> /visit Inpatient: 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.	
If you need help recovering or have other special health needs	Habilitation services	Outpatient: \$40 <u>copay</u> /visit Inpatient: 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.	
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 90 days per calendar year. <u>Prior</u> <u>authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.	
	Durable medical equipment	30% coinsurance	50% coinsurance	Prior authorization required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.	
	Hospice services	30% coinsurance	50% coinsurance	Limited to 240 respite hours, limited to 30 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.	
	Children's eye exam	Not covered	Not covered	None	
If your child needs	Children's glasses	Not covered	Not covered	None	
dental or eye care	Children's dental check- up	Not covered	Not covered	None	

### Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
Bariatric surgery	<ul> <li>Infertility treatment</li> </ul>	<ul> <li>Private-duty nursing</li> </ul>		
Cosmetic surgery	Long-term care	<ul> <li>Routine eye care (Adult)</li> </ul>		
Dental care (Adult)		Weight loss programs		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)				
Acupuncture	Foot care	<ul> <li>Non-emergency care when traveling outside the</li> </ul>		
Chiropractic care or other spinal manipulations	Hearing aids	U.S.		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA <u>plans</u>, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>. For governmental <u>plans</u>, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>. For church <u>plans</u> and all other <u>plans</u>, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 711. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: your <u>plan</u> at 1-800-722-1471 or TTY 711, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>.

#### Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

#### Does this plan meet the Minimum Value Standards? Yes.

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

#### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471. Chinese (中文): 如果需要中文的帮助,请拨打这个号码1-800-722-1471. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-800-722-1471.

----To see examples of how this plan might cover costs for a sample medical situation, see the next section.--



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

	Peg is Having a E	Baby		
(9 months of in-network pre-natal care and a				
	hospital delivery	)		

\$2,000
\$40
30%
30%

This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

	Total Example Cost	\$12,700
Ir	n this example, Peg would pay:	
	<u>Cost Sharing</u>	
	<u>Deductibles</u>	\$2,000
	<u>Copayments</u>	\$10
	Coinsurance	\$2,700
	What isn't covered	

Limits or exclusions

The total Peg would pay is

\$2.000	The plan's overall deductible \$2,00	0	
al care and a	(a year of routine in-network care of a well- controlled condition)		

\$60

\$4,770

\$2,000
\$40
30%
30%

Managing Joe's type 2 Diabetes

This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)

	Total Example Cost	\$5,600
Ir	n this example, Joe would pay:	
	<u>Cost Sharing</u>	
	Deductibles	\$30
	Copayments	\$1,700
	Coinsurance	\$0

What isn't covered Limits or exclusions \$20 The total Joe would pay is \$1.750

**Mia's Simple Fracture** (in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u>	\$2,000
Specialist copay	\$40
Hospital (facility) <u>coinsurance</u>	30%
Other <u>coinsurance</u>	30%

## This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
I Utal Example COSt	φ2,000

### In this example. Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$2,000	
<u>Copayments</u>	\$400	
Coinsurance	\$10	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,410	

#### Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as gualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInguiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

#### Language Assistance

<u>ATENCIÓN</u>: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711). 注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。 <u>CHÚÝ</u>: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711). <u>주의</u>: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오. <u>ВНИМАНИЕ</u>: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайл: 711). <u>РАШNAWA</u>: Кипg nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Титаwag sa 800-722-1471 (TTY: 711). <u>УВАГА!</u> Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

<u>ملحوظة:</u> إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711). <u>ਧਿਆਨ ਦਿਓ</u>: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। <u>ACHTUNG</u>: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711). <u>ਪਿਨਕੁਹਾਹ</u>: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລຶການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມືພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711). <u>ATANSYON</u>: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

<u>ATTENTION</u> : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711). <u>UWAGA</u>: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

<u>ATTENZIONE</u>: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711). **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 712-250-800 تماس بگیرید.

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