Summary of Benefits and Coverage: What this <u>Plan</u> Covers & What You Pay For Covered Services Premera Blue Cross : HSA 5500

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would **4** share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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 allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 711) to request a copy. **Important Questions** Why This Matters: Answers Calendar year aggregate Generally, you must pay all of the costs from providers up to the deductible amount before this What is the overall deductible. \$5,500 Individual / plan begins to pay. If you have other family members on the policy, the overall family deductible deductible? must be met before the plan begins to pay. \$6,000 Family. This plan covers some items and services even if you haven't yet met the deductible amount. Are there services Yes. Does not apply to Preventive But a copayment or coinsurance may apply. For example, this plan covers certain preventive covered before you meet care and services listed below as services without cost-sharing and before you meet your deductible. See a list of covered "No charge" your deductible? preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. Are there other No. You don't have to meet deductibles for specific services. deductibles for specific services? The out-of-pocket limit is the most you could pay in a year for covered services. If you have What is the out-of-pocket other family members in this plan, they have to meet their own out-of-pocket limits until the \$6,500 Individual / \$13,000 Family limit for this plan? overall family out-of-pocket limit has been met. Premium, balance-billed charges, penalties for failure to obtain prior What is not included in Even though you pay these expenses, they don't count toward the out-of-pocket limit. the out-of-pocket limit? authorization for services, and health care this plan doesn't cover. This plan uses a provider network. You will pay less if you use a provider in the plan's network. Yes. See www.premera.com or call You will pay the most if you use an out-of-network provider, and you might receive a bill from a Will you pay less if you provider for the difference between the provider's charge and what your plan pays (balance 1-800-722-1471 for a list of network use a network provider? providers. billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. Do you need a referral to No. You can see the specialist you choose without a referral. see a specialist?



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

Common Medical Event	Services You May Need	What Yo <u>Network Provider</u> (You will pay the least)	u Will Pay <u>Out-of-Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
If you visit a health	<u>Specialist</u> visit	20% coinsurance	40% coinsurance	None
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge	40% <u>coinsurance</u> (<u>deductible</u> does not apply)	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)	20% coinsurance	40% coinsurance	None
lf you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% coinsurance	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	20% <u>coinsurance</u>	20% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
More information about	Preferred brand drugs	20% coinsurance	20% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). <u>Prior authorization</u> required for some drugs.
prescription drug coverage is available at	Non-preferred brand drugs	20% coinsurance	20% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). <u>Prior authorization</u> required for some drugs.
https://www.premera.co m/documents/052148_2 024.pdf	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior <u>authorization</u> required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
	Physician/surgeon fees 20% coinsurance 40% coinsura		40% coinsurance	None

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	
	Emergency room care	20% coinsurance	20% <u>coinsurance</u>	None	
If you need immediate	Emergency medical transportation	20% coinsurance	20% coinsurance	None	
medical attention	Urgent care	20% <u>coinsurance</u>	Hospital-based: 20% <u>coinsurance</u> Freestanding center: 40% <u>coinsurance</u>	None	
lf you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
If you need mental	Outpatient services	20% coinsurance	40% coinsurance	None	
health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.	
lf you are pregnant	Office visits	20% <u>coinsurance</u>	40% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).	
	Childbirth/delivery facility services 20% coinsurance		40% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may 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	20% coinsurance	40% coinsurance	Limited to 130 visits per calendar year	
	Rehabilitation services	20% <u>coinsurance</u>	40% coinsurance	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	20% <u>coinsurance</u>	40% coinsurance	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	20% coinsurance	40% 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	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	Limited to 240 respite hours, limited to 30 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.	
If your child needs	Children's eye exam	Not covered	Not covered	None	
dental or eye care	Children's glasses	Not covered	Not covered	None	
	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	 Infertility treatment 	 Private-duty nursing 		
Cosmetic surgery	Long-term care	 Routine eye care (Adult) 		
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	 Non-emergency care when traveling outside the 		
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</u> Insurance <u>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 Ba (9 months of in-network pre-natal hospital delivery)		Managing Joe's type 2 Di (a year of routine in-network care controlled condition)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,500 20% 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,500 20% 20% 20%
This EXAMPLE event includes serv Specialist office visits (prenatal care) Childbirth/Delivery Professional Service		This EXAMPLE event includes serv Primary care physician office visits (in disease education)	

\$6,560

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>	\$5,500
	<u>Copayments</u>	\$0
	<u>Coinsurance</u>	\$1,000
	What isn't covered	
	Limits or exclusions	\$60

The total Peg would pay is

The plan's overall deductible	\$5,500
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

s like: dina Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)

	Total Example Cost	\$5,600
lr	n this example, Joe would pay:	
	<u>Cost Sharing</u>	
	<u>Deductibles</u>	\$5,400
	<u>Copayments</u>	\$0
	Coinsurance	\$0
	What isn't covered	
	Limits or exclusions	\$20

\$5.420

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

The plan's overall deductible	\$5,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other <u>coinsurance</u>	20%

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
	+- , •••

In this example. Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$2,800	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

The total Joe would pay is

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>BHUMAHUE</u>: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711). <u>PAUNAWA</u>: Киng nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag 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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມືພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711). <u>ATANSYON</u>: Si w pale Kreyol 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). <u>ATENÇÃO</u>: 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) TTY: 7

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