Coverage for: Individual or Family | Plan 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: 1-800-842-5357) 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 https://www.healthcare.gov/sbc-qlossary/ or call 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$750 Individual / \$2,250 Family. Out-of-network: \$1,500 Individual / \$4,500 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 deductible?	Yes. Does not apply to <u>Preventive</u> care, copayments, prescription drugs 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> services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles 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> ?	In-network: \$4,400 Individual / \$9,500 Family, Out-of-network: \$8,800 Individual / \$19,000 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> ?	Premium, balance-billed charges, and health care this plan 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 network providers.	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 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 specialist you choose without a referral.

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

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	
	Primary care visit to treat an injury or illness	\$30 copay/visit	40% <u>coinsurance</u>	None	
If you visit a health	Specialist visit	\$45 <u>copay</u> /visit	40% <u>coinsurance</u>	None	
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge	Not covered	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% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization recommended for some outpatient imaging tests. Penalty for out-of-network: no penalty.	
If you need drugs to treat your illness or condition	Preferred generic drugs	\$10 <u>copay</u> /prescription (retail), \$25 <u>copay</u> /prescription (mail)	\$10 <u>copay</u> /prescription + 40% <u>coinsurance</u> (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> recommended for some drugs.	
More information about prescription drug	Preferred brand drugs	\$30 <u>copay</u> /prescription (retail), \$75 <u>copay</u> /prescription (mail)	\$30 <u>copay</u> /prescription + 40% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization recommended for some drugs.	
coverage is available at https://www.premera.co m/documents/052149.p	Preferred <u>specialty drugs</u>	\$50 <u>copay</u> /prescription	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs. SaveonSP affects your cost share for certain drugs. See www.premera.com/saveonsp for more information.	

Common		What Yo	u Will Pay	Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
<u>df</u>	Non-preferred generic drugs Non-preferred brand drugs Non-preferred <u>specialty drugs</u>	Non-pref. generic: 30% coinsurance Non-pref. brand: 30% coinsurance Non-pref. specialty: 30% coinsurance	Non-pref. generic: 30% coinsurance + 40% coinsurance (retail), not covered (mail) Non-pref. brand: 30% coinsurance + 40% coinsurance (retail), not covered (mail) Non-pref. specialty: Not covered	Non-pref. generic and non-pref. brand: Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Non-pref. specialty drugs: Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs. SaveonSP affects your cost share for certain drugs. See www.premera.com/saveonsp for more information.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization recommended for some services. Penalty for out-of-network: no penalty.	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
	Emergency room care	\$300 <u>copay</u> /visit + 20% <u>coinsurance</u> (<u>deductible</u> does not apply)	\$300 <u>copay</u> /visit + 20% <u>coinsurance</u> (<u>deductible</u> does not apply)	Emergency room <u>copay</u> waived if admitted to hospital.	
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None	
If you need immediate medical attention	<u>Urgent care</u>	Hospital-based: \$300 copay/visit + 20% coinsurance (deductible does not apply) Freestanding center: \$30 copay/visit Non- Specialist, \$45 copay/visit Specialist	Hospital-based: \$300 copay/visit + 20% coinsurance (deductible does not apply) Freestanding center: 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	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
If you need mental health, behavioral	Outpatient services	Office Visit: \$30 <u>copay</u> /visit Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).	

Common		What Yo	u Will Pay	Limitations, Exceptions, & Other Important
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Rehabilitation services	Outpatient: \$45 copay/visit Inpatient: 20% coinsurance	40% <u>coinsurance</u>	Limited to 45 outpatient visits per plan year, limited to 30 inpatient days per plan year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
If you need help recovering or have other special health needs	Habilitation services	Outpatient: \$45 copay/visit Inpatient: 20% coinsurance	40% <u>coinsurance</u>	Limited to 45 outpatient visits per plan year, limited to 30 inpatient days per plan year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per plan year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> recommended to buy some medical equipment. Penalty for out-of-network: no penalty.
	Hospice services	20% coinsurance	40% <u>coinsurance</u>	6 months of care with additional 6 months if needed
If your child needs dental or eye care	Children's eye exam	\$30 <u>copay</u> /visit	\$30 <u>copay</u> /visit	Limited to one exam per plan year (under age 19).
	Children's glasses	No charge	No charge	Frames and lenses: Limited to one pair per plan year (under age 19).
	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 surgeryDental care (Adult)

Long-term care

Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care or other spinal manipulations
- Foot care
- Hearing aids

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-722-1471 or TTY 1-800-842-5357, 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 www.dol.gov/ebsa/healthreform.

Does this <u>plan</u> provide <u>Minimum Essential Coverage</u>? 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 plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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, kwiijigo holne' 1-800-722-1471.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
Specialist copay	\$45
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

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
In this example, Peg would pay:	

Cost Sharing			
<u>Deductibles</u>	\$750		
<u>Copayments</u>	\$10		
<u>Coinsurance</u>	\$2,400		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is \$3,220			

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ Specialist copay	\$45
■ Hospital (facility) coinsurance	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>		
<u>Deductibles</u>	\$200	
Copayments	\$1,300	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,520	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$750
■ Specialist copay	\$45
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,750

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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 qualified 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, or sex, 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 AppealsDepartmentInquiries@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.isf. 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.

Language Assistance

ATENCIÓN: 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)。 CHÚ Ý: 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). 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).
- УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។
- 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。
- *ማ*ስታወሻ: የሚናንሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስጣት ለተሳናቸው: 711).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711). ملحوظة. إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتو افر لك بالمجان. اتصل برقم 1471-722-800 رقم هاتف الصم والبكم: 711).
- ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
- Rufnummer: 800-722-1471 (TTY: 711). ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).
- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).
- UWAGA: 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 servicos linguísticos, grátis. Lique para 800-722-1471 (TTY: 711).
- ATTENZIONE: 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 (۲۲۱: ۲۲۲) 1471-722-800 تماس بگیرید.