HMO Plan

School Employees Benefits Board (SEBB) Program
January 1, 2027 through December 31, 2027

PREMERA HMO

PCY = per calendar year; OOP = out of pocket

Monthly employee premium Employee only / Employee+Spouse* / Employee+Child(ren) / Employee+Spouse*+Child(ren)	**Clearwater HMO Network** **$38 / $76 / $67 / $114**	
	In network	**Out of network**
Annual medical deductible	$750 individual / $1,500 family	Not covered
Coinsurance	20%	
Out-of-pocket maximum (OOP max): Emp/Family Includes deductible, coinsurance, and copays	$3,500 individual / $7,000 family	
Office visit copay (deductible waived) Includes naturopathy services	$10 copay nonspecialist (deductible waived) / $40 copay specialist (deductible waived)	
Urgent care	$40 copay (deductible waived)	
Virtual care (deductible waived) General medical / dermatology Behavioral health	$5 copay (deductible waived) $10 copay (deductible waived)	Not covered
Alternative care Spinal manipulation: 24 visits PCY Acupuncture: 24 visits PCY Massage therapy: 24 visits PCY	$10 copay (deductible waived)	
Emergency services Emergency care (copay waived if directly admitted to an inpatient facility) Ambulance transportation (air and ground)	$175 copay, then deductible, then 20% Deductible, then 20%	
Hospitalization Inpatient and outpatient services Organ and tissue transplants	Deductible, then 20% Ambulatory surgical centers (ASC): Deductible, then 10%	Not covered
Maternity and newborn care (includes doula coverage)	Deductible, then 20% Deductible, then 10% at a birthing center	
Mental health and substance use disorder services, including behavioral health Office visit Inpatient and outpatient hospital: mental/behavioral health	$10 copay (deductible waived) Deductible, then 20%	
Rehabilitative and habilitative services and devices Inpatient: Physical, speech, occupational (45 days combined PCY); Neurodevelopmental (45 days PCY) Outpatient: Physical, speech, occupational (45 visits combined PCY); Neurodevelopmental (45 visits PCY) Durable medical equipment	Deductible, then 20% $40 copay (deductible waived) Deductible, then 20%	
Laboratory services Includes x-ray, pathology, imaging/diagnostic, standard ultrasound Major imaging including MRI, CT, PET	Basic: $75 copay Major: $150 copay	
Preventive and wellness services Screenings Exams and vaccinations	$0 (deductible waived)	
Hearing Exam: 1 PCY Hardware	Exam: Plan covers at 100% Hardware: One hearing instrument per ear, with hearing loss, covered in full every 3 calendar years (deductible waived)	Exam: Not covered Hardware: One hearing instrument per ear, with hearing loss, covered in full every 3 calendar years (deductible waived)
Annual prescription deductible PCY	No Rx deductible	
Prescription drugs Retail and mail order: Up to a 90-day supply Specialty Rx: 30-day supply Preferred generic Preferred brand Preferred specialty (30-day supply; mail order or Walgreens Specialty Pharmacy) Non-preferred drugs	Applies to medical OOP max for in-network prescriptions. The member pays the difference when requesting a brand-name drug. $9 per 30-day supply at retail pharmacy/ $27 for 90-day supply via mail order; $40 per 30-day supply at retail pharmacy/ $120 for 90-day supply via mail order; 50%	Cost share, then 40% (to allowable amount) Not covered for mail order
Drug list (view full E4 drug list at **premera.com/sebb**)	E4	E4

Choose a plan based on the county where you live or work. Premera Blue Cross HMO health plan is available in these counties:
King, Pierce, Snohomish, Spokane, and Thurston counties.

*Or state-registered domestic partner

Understanding your health plan should be simple and easy

To help you understand key healthcare terms, review the glossary below.

Allowed amount: The amount Premera Blue Cross HMO pays for healthcare services. When you receive services from in-network providers, you'll be responsible for cost shares (deductibles, copays, and coinsurance) and charges for services not covered by the health plan. The allowed amount for an out-of-network provider is determined by Premera Blue Cross HMO. Innetwork providers will not bill you for charges over the allowed amount.

If you receive services from an out-of-network provider, you will be responsible for the difference between the allowed amount and the provider's billed charges, in addition to the deductible, coinsurance, and any applicable copay. This is called balance billing.

Coinsurance: Your percentage of the cost for a service. With the exception of some services, you pay 100% until your deductible is paid for the calendar year. After that, if your plan's coinsurance is 20%, you pay 20% of the allowed amount and your plan pays the other 80%.

Copay: This is a flat fee you pay for a specific service (such as an office visit) at the time you receive the service.

Cost share: The part of healthcare costs that a member pays, such as deductibles, coinsurance, and copay. It does not include monthly health plan bills, amounts balance billed by healthcare providers who are out of your plan network, or the cost of services not included in your plan.

Deductible: The amount you pay in medical costs before your health plan begins to pay. (The deductible does not apply to some services.) Amounts over the allowed amount for the service do not count toward the deductible.

Drug list: A list, sometimes called a formulary, of prescription drugs covered by the plan. Not all drugs are included in every drug list.

In network: Doctors, pharmacies, hospitals, and other healthcare providers that are contracted to provide services and supplies at negotiated amounts, called allowed amounts.

Out-of-pocket maximum: The maximum of allowed amounts you will pay for covered services from an in-network provider per calendar year. After you've met your out-of-pocket maximum, the plan pays 100% for in-network covered services for the rest of the year.

Plan covers at 100%: A benefit that does not require cost shares. You do not pay deductibles, coinsurance, or copays for services that are covered in full.

Urgent care: Conditions that need treatment right away but are not severe or life threatening. Urgent care is subject to a $50 copay when received in or out of network.

Virtual care: Talk with a provider by phone, texting, or online video.

General exclusions and limitations

Below is a list of some services and supplies that this health plan does not cover. A complete list of exclusions is available on **premera.com/sebb**.

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

- Services that are not medically necessary
- Cosmetic surgery or reconstructive surgery (except as specifically provided)
- Experimental or investigational services
- Assisted reproduction
- Weight loss drugs, foods, and exercise programs
- Services in excess of specific benefit maximums
- Services payable by other types of insurance, such as property insurance, liability insurance, or motor vehicle insurance
- Services received when you are not covered by this plan
- Services that the provider's license or certification does not allow them to perform. It also does not cover a provider that does not have the license or certification that the state requires.
- Sexual dysfunction
- Sterilization reversal

Some services, equipment, and drugs require prior authorization from Premera Blue Cross HMO to be covered. For a list of services and procedures that require preapproval for coverage from your plan before you receive them, visit **premera.com/sebb**.

This document is not a contract. It is only a summary of major benefits provided by these plans. On our website, you can find the Summary of Benefits and Coverage (SBC) and benefits booklets.

Contact us

For enrollment information or if you have questions about the SEBB health plans offered by Premera Blue Cross and Premera Blue Cross HMO:

- Visit **premera.com/sebb**
- Call **800-807-7310 (TRS: 711)**, Monday through Friday, 5 a.m. to 8 p.m. Pacific Time

For information about Premera Blue Cross HMO please visit **hmo.premera.com**

New members

Sign up for Digital Health Messages:

Create your Premera Blue Cross HMO account:

Returning members

Sign in to your account:

Premera Blue Cross HMO and Premera Blue Cross are Independent Licensees of the Blue Cross Blue Shield Association

Notice of availability and nondiscrimination **800-807-7310 | TRS: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross HMO complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera Blue Cross HMO does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera Blue Cross HMO provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 Blue Cross HMO provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera Blue Cross HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TRS: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.

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059688 (07-05-2024)