

Preferred Choice HSA: \$3,000

Healthcare services in your plan starting January 1, 2019

For a full list of services, visit our website at premera.com or call customer service at 800-722-1471.

Refer to your Premera ID card for network information.

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

COST SHARES The portion of health care costs that are your responsibility.	IN-NETWORK Services from healthcare professionals that Premera has contracted with.	OUT-OF-NETWORK Services from healthcare professionals that Premera has not contracted with.
DEDUCTIBLE (Family aggregate deductible 2x individual) The amount you pay each year before the health plan starts to pay for services. Copays do not count toward fulfilling your deductible	\$3,000	\$6,000
COINSURANCE A percentage of healthcare costs you start paying after you've met your deductible	20%	50%
OUT-OF-POCKET MAXIMUM (Family embedded 2x individual) The most you will have to pay for services before your health plan begins to pay 100%	\$6,000	Unlimited
COMMON SERVICES		
OFFICE VISITS Visit to primary care provider or specialist to treat an injury or illness	20% coinsurance	50% coinsurance
PREVENTIVE OFFICE VISITS / IMMUNIZATIONS Including annual wellness exams and seasonal vaccinations	No charge	Not covered
TESTS		
DIAGNOSTIC TESTS Including x-ray, blood work, lab work	20% coinsurance	50% coinsurance
IMAGING TESTS Including CT / PET scans, MRIs	20% coinsurance	50% coinsurance
PREVENTIVE DIAGNOSTIC IMAGING AND LAB SERVICES Including mammograms and PAP tests	No charge	50% coinsurance
IMMEDIATE MEDICAL ATTENTION		
EMERGENCY ROOM CARE Injury that is a threat to life or limb	20% coinsurance	
URGENT CARE (freestanding center) Injury that is NOT a threat to life or limb	20% coinsurance	50% coinsurance
HOSPITAL STAY		
FACILITY Fees associated with hospital room	20% coinsurance	50% coinsurance
PHYSICIAN / SURGEON Fees associated with medical care	20% coinsurance	50% coinsurance
OTHER		
ALLERGY / THERAPEUTIC INJECTIONS	20% coinsurance	50% coinsurance
RECOVERY AND SPECIAL HEALTH NEEDS Including physical, occupational, speech, and massage therapy	20% coinsurance	50% coinsurance

PRESCRIPTION DRUGS	IN-NETWORK	OUT-OF-NETWORK
RETAIL COST SHARE Copayment you'll pay for prescriptions picked up at a pharmacy	20% coinsurance	
MAIL COST SHARE Copayment you'll pay for prescriptions filled through mail order	20% coinsurance	Not covered
DAYS SUPPLY	Retail: 90 days Mail: 90 days	
	Specialty: 30 days	Specialty: Not covered
DRUG LIST	Open A1	

Other covered services

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

20% coinsurance

- Outpatient rehab (45 visits)
- Acupuncture (12 visits)
- Chiropractic care (12 visits)
- Outpatient mental health (unlimited)

\$25 Copay

- Routine (adult) eye exam (1)
- Pediatric (under age 19) eye exam (1)

Covered in Full

- Vision Hardware (\$150 every 2 consecutive calendar years)

20% coinsurance

- Emergency medical transportation
- Maternity care
- Home health care (130 visits)
- Inpatient rehab facility (30 days)
- Skilled nursing care (60 days)
- Inpatient mental health (unlimited)

**Days/visits/limits are per calendar year. Cost shares are based on in-network services. See your plan document for out-of-network cost shares. All copay and coinsurance costs are after your deductible has been met, if a deductible applies.*

Services your plan generally does NOT cover

(Check your policy or plan document for more information and a list of any other excluded services.)

- Assisted fertilization treatment
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Private-duty nursing
- Weight loss programs
- Hearing aids

Premera Pulse

Premera Pulse is a digital resource to help find care, manage your medications, and get reminders of recommended screenings. Text **PULSE** to **24248** to activate your account.

Teladoc®

Visit a doctor without leaving home. Set up an account now so you're able to have a video consultation when you need it. Go to teladoc.com/premera or call **855-332-4059** to register.*

For more information about programs and resources your health plan offers, log in at premera.com and select My Premera Plan.

*Teladoc operates subject to state regulation and may not be available in certain states. Video consultations through Teladoc are available 7 a.m. to 9 p.m., 7 days a week. Teladoc® is an independent company that arranges virtual medical care services on behalf of Premera Blue Cross.



An Independent Licensee of the Blue Cross Blue Shield Association

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 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, 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 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.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

- 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 ដោយមិនគិតល្អល្អ គឺអាចមានសំរាប់អ្នក។ 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。
- ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።
- XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).
- ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ 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 ທ່ານວົາພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສິ່ງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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 serviços linguísticos, grátis. Ligue 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 بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.