

# Highlights of your Health Care Coverage

Effective Date: 01/01/2022

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.  
 Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN		PEAK CARE 1000 GOLD	
	TAHOMA AND DENTAL CHOICE IN- NETWORK	OUT-OF-NETWORK	
<b>Deductible</b> (In-network only - Family embedded deductible 2X Individual)	\$1,000	Not Covered	
<b>Coinsurance</b>	20%	Not Covered	
<b>Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy)</b> (Family embedded OOP max 2X Individual)	\$8,300	Not Covered	
<b>Office Visit Cost Share</b>	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum; \$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Annual Maximum</b>	Unlimited	Unlimited	
<b>1 Ambulatory Patient Services</b>			
<b>Professional Office Visit</b>	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum; \$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Telemedicine by Traditional Provider – General Medical</b>	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum; \$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Urgent Care Office Visits</b>	\$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	

<b>MEDICAL PLAN</b>		<b>PEAK CARE 1000 GOLD</b>	
	<b>TAHOMA AND DENTAL CHOICE IN- NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Outpatient Professional Services</b>	\$1,000 Deductible, then 20% Coinsurance, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	Not Covered	
<b>2 Emergency and Transportation Services</b>			
<b>Emergency Room - facility</b>	\$450, applies to the OOP Max, then Subject to Deductible, then Coinsurance	\$450, applies to the OOP Max, then Subject to Deductible, then Coinsurance	
<b>Ambulance Service - ground</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	
<b>Ambulance Service - air</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	
<b>3 Hospitalization</b>			
<b>Inpatient Medical and Surgical Room and Board</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Skilled Nursing Facility</b> (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Hospice Inpatient Facility</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Inpatient Professional Services</b>	\$1,000 Deductible, then 20% Coinsurance, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Organ Transplants</b> (Unlimited; \$5,000 travel and lodging limits)	Covered as any other service	Not Covered	
<b>4 Maternity &amp; Newborn Care</b>			
<b>Prenatal, Delivery, Postnatal</b> (Coverage for subscriber, spouse, dependent)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>5 Mental Health &amp; Substance Use Disorder Services, including Behavioral Health Treatment</b>			
<b>Chemical Dependency Office Visit</b> (Unlimited)	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Chemical Dependency Outpatient Facility</b> (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Chemical Dependency Inpatient Facility</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Mental Health Office Visit</b> (Unlimited)	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Mental Health Outpatient Facility</b> (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Mental Health Inpatient Facility</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	

MEDICAL PLAN		PEAK CARE 1000 GOLD	
	TAHOMA AND DENTAL CHOICE IN- NETWORK	OUT-OF-NETWORK	
<b>6 Prescription Drug</b>			
<b>Drug List</b>	M4 Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = non-preferred generic and brand Tier 4 = specialty	Not Covered	
<b>Retail (preferred generic/preferred brand/non-preferred)</b> (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive Deductible, then \$15/ Waive Deductible, then \$40/ Waive Deductible, then \$80; all cost shares apply to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Mail Order (preferred generic/preferred brand/non-preferred)</b> (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive Deductible, then \$45/ Waive Deductible, then \$120/ Waive Deductible, then \$240; all cost shares apply to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Specialty Rx</b> (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive Deductible, then 25% Coinsurance applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>7 Rehabilitative &amp; Habilitative Services &amp; Devices</b>			
<b>Inpatient Rehabilitation</b> (30 days PCY combined limit for inpatient services)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Inpatient Habilitation</b> (30 days PCY combined limit for inpatient services)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Rehab Outpatient Professional - physical, speech, occupational therapy</b> (25 visits PCY combined limit for outpatient services)	\$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Habilitation Outpatient Professional - physical, speech, occupational therapy</b> (25 visits PCY combined limit for outpatient services)	\$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Massage Therapy</b> (Applies to rehab)	\$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Durable Medical Equipment</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>8 Laboratory/Imaging Services</b>			
<b>Pathology</b>	Waive Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Imaging - basic</b>	Waive Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Imaging - major (MRI, CT, PET)</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	

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<b>Diagnostic Mammography</b>	Waive Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>9 Preventive/Wellness Services &amp; Chronic Disease Management</b>			
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Preventive Laboratory Screens</b>	Covered in Full	Not Covered	
<b>Preventive Imaging</b>	Covered in Full	Not Covered	
<b>Preventive Routine Mammography</b>	Covered in Full	Not Covered	
<b>10 Pediatric Services, including Oral &amp; Vision Care</b>			
<b>Pediatric Vision Exam</b> (1 PCY Under age 19)	\$50 Copay Specialist and non designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Pediatric Eyewear</b> (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered in Full	
<b>Pediatric Dental (preventive)</b>	Covered in Full	Not Covered	
<b>Pediatric Dental (basic)</b>	Waive Medical Deductible, then 20% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Pediatric Dental (major)</b>	Medical \$1,000 Deductible, then 50% Coinsurance, applies to \$8,300 Out of Pocket Maximum	Not Covered	
<b>Virtual Care Services</b>			
<b>Telemedicine – General Medical (Virtual Care Only)</b>	\$5 Copay, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
<b>Routine Hearing</b>			
<b>Routine Hearing Exam</b> (1 every 2 calendar years)	\$50 Copay	Not Covered	
<b>Routine Hearing Aids and Hardware</b> (\$1000 every 3 calendar years)	Covered in Full	Covered in Full	
<b>Alternative Care</b>			
<b>Chiropractic</b> (10 visits PCY)	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Acupuncture</b> (12 visits PCY)	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	
<b>Naturopath</b> (Unlimited)	\$20 Copay designated PCP, applies to the \$8,300 Out of Pocket Maximum	Not Covered	

MEDICAL PLAN	PEAK CARE 1000 GOLD	
	TAHOMA AND DENTAL CHOICE IN- NETWORK	OUT-OF-NETWORK
<b>Centers of Excellence Packaged Services</b> (No Eligible Services)	Covered as any other service	Not Covered
<b>Centers of Excellence for Radiology</b> (Member Outreach Excluded)	Covered as any other service	Not Covered

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

*This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.*

### 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](mailto: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 ដោយមិនគិតលុយ 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)።

**XIYYEEFFANNA:** 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).

**ໂປດອຸບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສິ່ງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sévis 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).

**توجہ:** اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.