Highlights of your Health Care Coverage

Effective Date: 01/01/2023

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 6000 BRONZE**	
	TAHOMA AND DENTAL CHOICE IN-NEWORK	**OUT-OF-NETWORK**
Deductible (In-network only - Family embedded deductible 2X Individual)	$6,000	Not Covered
Coinsurance	35%	Not Covered
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$8,900	Not Covered
Office Visit Cost Share	$55 Copay designated PCP, applies to the $8,900 Out of Pocket Maximum; $120 Copay Specialist and non designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit	$55 Copay designated PCP, applies to the $8,900 Out of Pocket Maximum; $120 Copay Specialist and non designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Telemedicine by Traditional Provider – General Medical	$55 Copay designated PCP, applies to the $8,900 Out of Pocket Maximum; $120 Copay Specialist and non designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Urgent Care Office Visits	$120 Copay Specialist and non designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Outpatient Professional Services	$6,000 Deductible, then 35% Coinsurance, applies to the $8,900 Out of Pocket Maximum	Not Covered
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
2 Emergency and Transportation Services		

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MEDICAL PLAN	PEAK CARE 6000 BRONZE	
	TAHOMA AND DENTAL CHOICE IN-NEWORK	OUT-OF-NETWORK
Emergency Room - facility	$450, applies to the OOP Max, then Subject to Deductible, then Coinsurance	$450, applies to the OOP Max, then Subject to Deductible, then Coinsurance
Ambulance Service - ground (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum
Ambulance Service - air (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Hospice Inpatient Facility (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$6,000 Deductible, then 35% Coinsurance, applies to the $8,900 Out of Pocket Maximum	Not Covered
Organ Transplants (Unlimited)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	PCP Copay (designation not required), applies to the $8,900 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Facility (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Chemical Dependency Inpatient Facility (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Mental Health Office Visit (Unlimited)	PCP Copay (designation not required), applies to the $8,900 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Facility (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
6 Prescription Drug		

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MEDICAL PLAN	PEAK CARE 6000 BRONZE	
	TAHOMA AND DENTAL CHOICE IN-NEWORK	**OUT-OF-NETWORK**
Drug List	M4 Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = non-preferred generic and brand Tier 4 = specialty	Not Covered
Prescription Drugs - Retail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	$35/Subject to Deductible, then $45, applies to OOP Max/Subject to Deductible, then 40%/Subject to Deductible, then 40%	Not Covered
Prescription Drugs - Mail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	$105/Subject to Deductible, then $135, applies to OOP Max/Subject to Deductible, then 40%/Subject to Deductible, then 40%	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Rehab Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Habilitation Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Massage Therapy (Applies to rehab)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Durable Medical Equipment (Unlimited)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
8 Laboratory/Imaging Services		
Pathology	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Imaging - basic	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Imaging - major (MRI, CT, PET)	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Diagnostic Mammography	$6,000 Deductible, then 35% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
9 Preventive/Wellness Services & Chronic Disease Management		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Preventive Laboratory Screens	Covered in Full	Not Covered
Preventive Imaging	Covered in Full	Not Covered
Preventive Routine Mammography	Covered in Full	Not Covered

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MEDICAL PLAN	PEAK CARE 6000 BRONZE	
	TAHOMA AND DENTAL CHOICE IN-NEWORK	OUT-OF-NETWORK
10 Pediatric Services, including Oral & Vision Care		
Pediatric Vision Exam (1 PCY Under age 19)	$120 Copay Specialist and non designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Pediatric Eyewear (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
Pediatric Dental (preventive)	Covered in Full	Not Covered
Pediatric Dental (basic)	Waive Medical Deductible, then 20% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Pediatric Dental (major)	Medical $6,000 Deductible, then 50% Coinsurance, applies to $8,900 Out of Pocket Maximum	Not Covered
Virtual Care Services		
Telemedicine – General Medical (Virtual Care Only)	$55 Copay designated PCP, applies to the $8,900 Out of Pocket Maximum; $120 Copay Specialist and non designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Routine Hearing		
Routine Hearing Exam (1 every 2 calendar years)	$120 Copay	Not Covered
Routine Hearing Aids and Hardware ($1000 every 3 calendar years)	Covered in Full	Covered in Full
Alternative Care		
Chiropractic (10 visits PCY)	$55 Copay designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Acupuncture (12 visits PCY)	$55 Copay designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Naturopath (Unlimited)	$55 Copay designated PCP, applies to the $8,900 Out of Pocket Maximum	Not Covered
Centers of Excellence Packaged Services (No Eligible Services)	Covered as any other service	Not Covered
Centers of Excellence for Radiology (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 of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

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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 ដោយមិនគិតឈ្នួល 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。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት 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 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 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 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 به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 800-722-1471 تماس بگیرید.