PREMERA BLUE CROSS

Microsoft

2023 Premera benefit plans at a glance

	HEALTH SAVINGS PLAN (HSP)		HEALTH CONNECT PLAN (HCP)		
Plan feature	**In-network**	**Out-of-network[1]**	**Health Connect network**	**Extended network**	**Out-of-network[1]**
HSA contribution This tax-free contribution from Microsoft is based on your role and coverage level. The Microsoft contribution is deposited in two equal installments in January and July. If you are enrolled in the plan for only part of the year, the contribution is adjusted based on a prorated calculation of full months of plan enrollment.	Employee only: $1,000 Employee + 1: $2,000 Employee + 2 or more: $2,500 *Amounts above represent funding for employees in levels 40–49 & 59 and above roles. For employees in levels 30–39 & 50–58 roles, funding is at $1,500, $3,000 and $3,750; respectively.*		N/A		
Annual deductible The deductible does not apply to preventive services for either in-network or out-of-network coverage	Employee only: $1,500 Employee + 1: $3,000 Employee + 2 or more: $3,750		N/A	$1,000 per person $3,000 per family	
Copayments A fixed amount you are required to pay for a service	N/A		$20 Primary Care Physician (PCP) visit/ $40 specialist/other office visit	N/A	
Coinsurance The percentage of the allowable charge that you are required to pay for a service	10%	30%	10%	40%	50%
Annual coinsurance maximum Includes coinsurance only	Employee only: $1,000 Employee + 1: $2,000 Employee + 2 or more: $2,500		N/A		
Annual out-of-pocket maximum Includes medical deductible, coinsurance, and copays	Employee only: $2,500 Employee + 1: $5,000 Employee + 2 or more: $6,250		$2,000 per person $6,000 per family		

[1]Out-of-network coverage under the plan is limited to the allowable charge; you are responsible for any amount charged above the allowable charge (also known as balance billing).
PCP = Primary Care Physician

Important Note: 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 summary is not a contract. For full coverage provisions, including a description of limitations and exclusions, please see Microsoft Summary Plan Description at aka.ms/benefits or contact Premera Blue Cross at 800-676-1411.

Premera Blue Cross is an independent licensee of the Blue Cross Blue Shield Association
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	HEALTH SAVINGS PLAN (HSP)		HEALTH CONNECT PLAN (HCP)		
Benefit	**In-network coverage**	**Out-of-network[1] coverage**	**Health Connect network coverage**	**Extended network coverage**	**Out-of-network[1] coverage**
Ambulance (Ground or Water)	90% after deductible		90%		
Air Ambulance	90% after deductible	90% of allowable charges, after deductible	90%		90% of allowable charges
Autism/ABA therapy	90% after deductible	90% of allowable charges, after deductible	90%		50% of allowable charges, after deductible
Chiropractic, massage, and acupuncture services	90% after deductible	70% of allowable charges, after deductible	$40 copay		50% of allowable charges, after deductible
	Combined 24-visit limit per member per calendar year		Combined 24-visit limit per member per calendar year		
Contraception	100%		100%		50% of allowable charges, after deductible
	Contraceptive devices and injections administered by a physician; prescription forms of contraception are covered under preventive care		*Contraceptive devices and injections administered by a physician; prescription forms of contraception are covered under preventive care*		
Diabetes health education	100%	100% of allowable charges	100%		50% of allowable charges, after deductible
Diagnostic services Lab and radiology	90% after deductible	90% of allowable charges, after deductible	90%		50% of allowable charges, after deductible
Emergency room care and professional services	90% after deductible	90% of allowable charges, after deductible	$250 copay (waived if admitted)		
Routine hearing exam and hardware	**Exam:** 90% after deductible	**Exam:** 70% of allowable charges, after deductible	**Exam:** $40 copay		**Exam:** 50% of allowable charges, after deductible
	Hardware: 90% after deductible $10,000 limit per member in a period of 3 consecutive calendar years		**Hardware:** 90% $10,000 limit per member in a period of 3 consecutive calendar years		
Home health care	90% after deductible	70% of allowable charges, after deductible	90%	60% after deductible	50% of allowable charges, after deductible
Hospice care	90% after deductible		90%	60% after deductible	50% after deductible
Hospital inpatient and outpatient	90% after deductible	70% of allowable charges, after deductible	90%	60% after deductible	50% of allowable charges, after deductible
Infertility Including medications	90% after deductible, within the Progyny provider network	Not covered	90%, within the Progyny provider network	Not covered	
International services	**Emergency care:** 90% after deductible **Non-emergency care:** 70% after deductible		**Emergency care:** $250 copay (waived if admitted) **Non-emergency care:** 60% after deductible		

	HEALTH SAVINGS PLAN (HSP)		HEALTH CONNECT PLAN (HCP)		
Maternity care	90% after deductible	70% of allowable charges, after deductible	90%	60% after deductible	50% of allowable charges, after deductible
Benefit	**In-network coverage**	**Out-of-network[1] coverage**	**Health Connect network coverage**	**Extended network coverage**	**Out-of-network[1] coverage**
Maternity care bundle Routine pregnancy and delivery care received within the Health Connect network	Not applicable	Not applicable	$500 copay	Not applicable	Not applicable
Medical equipment and supplies	90% after deductible	90% of allowable charges, after deductible	90%		50% of allowable charges, after deductible
Mental health and chemical dependency	90% after deductible for inpatient and outpatient services	90% of allowable charges, after deductible for inpatient and outpatient services	**Inpatient:** 90% **Outpatient:** $20 copay per visit		90% of allowable charges for inpatient and outpatient services
Office visit	90% after deductible	70% of allowable charges, after deductible	**PCP visit:** $20 copay **Specialist/other office visit:** $40 copay	60% after deductible	50% of allowable charges, after deductible
Prescription drugs: Retail pharmacy 30-day supply / 90-day supply for generic maintenance medications	90% after deductible		**Generic:** $10 copay **Brand preferred:** $30 copay **Brand non-preferred:** $60 copay		50% of allowable charges, after deductible
Prescription drugs: Mail order pharmacy 90-day supply	90% after deductible	Not covered	**Generic:** $20 copay **Brand preferred:** $60 copay **Brand non-preferred:** $120 copay		Not covered
Preventive care See Preventive Care and Preventive Drug lists for details on coverage	**Preventive services:** 100% **Preventive prescription drugs:** 100%	**Preventive services:** 100% of allowable charges **Preventive prescription drugs:** 100%	**Preventive services:** 100% **Preventive prescription drugs:** 100%	**Preventive services:** 100% **Preventive prescription drugs:** 100%	**Preventive services:** 50% of allowable charges, after deductible **Preventive prescription drugs:** 50% of allowable charges
Skilled nursing facility	90% after deductible	70% of allowable charges, after deductible	90%	60% after deductible	50% of allowable charges, after deductible
	120-day maximum per member per calendar year		120-day maximum per member per calendar year		
Urgent care	90% after deductible	70% of allowable charges, after deductible	$40 copay	60% after deductible	50% of allowable charges, after deductible
Vision care	**Exam:** 100%, 1 routine eye exam per member, per calendar year	**Exam:** 100% of allowable charges, 1 routine eye exam per member, per calendar year	**Exam:** 100%, 1 routine eye exam per member, per calendar year		**Exam:** 50% of allowable charges, after deductible, 1 routine eye exam per member, per calendar year

	HEALTH SAVINGS PLAN (HSP)		HEALTH CONNECT PLAN (HCP)	
	Vision hardware (glasses—including frames and lenses—and/or contacts): **Under age 19** – 1 pair of glasses **or** 1 pair of contacts (or one-year supply of disposable contacts) per calendar year covered at 100% of allowable charges **Ages 19 and older** – glasses and/or contacts covered at 100% up to the maximum benefit of $350 per member, per calendar year		**Vision hardware (glasses—including frames and lenses—and/or contacts):** **Under age 19** – 1 pair of glasses **or** 1 pair of contacts (or one-year supply of disposable contacts) per calendar year covered at 100% of allowable charges **Ages 19 and older** – glasses and/or contacts covered at 100% up to the maximum benefit of $350 per member, per calendar year	
	Lasik: 100%, up to the maximum benefit of $1,000 per member		**Lasik:** 100%, up to the maximum benefit of $1,000 per member	
Microsoft CARES **Employee Assistance Program**	24 sessions per calendar year	Not covered	24 sessions per calendar year	Not covered

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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 1471-722-800 (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, ໂດຍບໍ່ເສັງຄ່າ, 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) 1471-722-800 تماس بگیرید.