Peak Care EPO Plan

School Employees Benefits Board (SEBB) Program
Start date: January 1, 2020

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Monthly employee premium (emp) contribution Emp only / Emp+Spouse* / Emp+Child(ren) / Emp+Family	**Tahoma Network**	
	$31 / $62 / $54 / $93	
	In-network	**Out-of-network**
Annual medical deductible per calendar year (PCY)	$750 / $1,875	Not covered
Coinsurance	25%	
Out-of-pocket maximum (OOP max): Emp/Family Includes deductible, coinsurance, and copays	$3,500 / $7,000	
Office visit copay Includes naturopathy services	$20 non-specialist / $40 specialist	
Urgent care	Deductible, then 25%	
Virtual care General medical / dermatology Behavioral health	$5 copay $20 copay	
Alternative care Spinal manipulation: 12 visits PCY Acupuncture: 12 visits PCY Massage therapy: 12 visits PCY	Deductible, then 25%	
Emergency services Emergency care (copay waived if directly admitted to an inpatient facility) Ambulance transportation (air and ground)	$150 copay, then deductible, then 25% Deductible, then 25%	$150 copay, then deductible, then 25% Deductible, then 25%
Hospitalization Inpatient and outpatient services Organ and tissue transplants	Deductible, then 25%	Not covered
Maternity and newborn care	Deductible, then 25%	
Mental health and substance use disorder services, including behavioral health Office visit Inpatient and outpatient hospital: mental/behavioral health	$20 copay Deductible, then 25%	
Rehabilitative and habilitative services and devices Inpatient: 45 days PCY Outpatient: Physical, speech, occupational, neurodevelopmental therapy: 45 visits combined PCY Durable medical equipment	Deductible, then 25% $40 copay Deductible, then 25%	
Laboratory services Includes x-ray, pathology, imaging/diagnostic, standard ultrasound Major imaging including MRI, CT, PET	Deductible, then 25%	
Preventive and wellness services Screenings Exams and vaccinations	Plan covers at 100%	
Hearing Exam: 1 PCY Hardware	Plan covers at 100% $1,000 covered every 3 calendar years	Not covered $1,000 covered every 3 calendar years
Annual prescription deductible: PCY	$125 / $312	$125 / $312
Prescription drugs Retail and specialty: 30-day supply / Mail order: 90-day supply Preferred generic Preferred brand Preferred specialty Non-preferred drugs Drug list (view full E4 drug list at **premera.com/sebb**)	Applies to medical OOP max for in-network prescriptions. The difference will be paid by the member when requesting a brand name drug. $7 / $14 copay (deductible waived) $30 / $60 copay $50 copay 30% E4	Cost share, then 40% (to allowable amount) Not covered for mail order E4

*Or state-registered domestic partner

Premera Blue Cross Peak Care EPO health plan is available in these counties: Pierce, Spokane, and Thurston counties.

Understanding your health plan should be simple and easy

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

Allowed amount: The amount Premera 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. In-network providers will not bill you for charges over the allowed amount. If you receive services from out-of-network providers, you are responsible for all amounts not paid by Premera.

Coinsurance: Your percentage of the cost for a service. You pay 100% until your deductible is paid for the calendar year. After that, if your plan's coinsurance is 25%, you pay 25% of the allowed amount and your plan pays the other 75%.

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

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.

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

Drug list: A list, sometimes called a formulary, of 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.

Urgent care: Conditions that need treatment right away but are not severe or life threatening. For urgent conditions, care for an out-of-network provider is not covered.

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

If you receive services from a non-contracted 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. The allowed amount for a non-contracted provider is determined by Premera Blue Cross.

General exclusions and limitations

Below is a list of some services or 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, including surgery, 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 him or her 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
- Services from out-of-network providers, except for emergency care

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

Contact us

For enrollment information or if you have questions about Premera Blue Cross SEBB plans:

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

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 Continuity of Care (CoC) documents.

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Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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, or sex, 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, TRS: 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-807-7310 (TRS: 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 800-807-7310（TRS：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-807-7310 (TRS: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-807-7310 (TRS: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-807-7310 (служба коммутируемых сообщений: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-807-7310 (TRS: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-807-7310 (служба комутованих повідомлень: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-807-7310 (TRS: 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。800-807-7310（TRS:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-807-7310 (በስልክ ማገናኛ አገልግሎት: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-807-7310 (TRS: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-807-7310 (رقم خدمة ترحيل الاتصالات للصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-807-7310 (TRS: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-807-7310 (TRS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-807-7310 (TRS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-807-7310 (TRS: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-807-7310 (SRT : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-807-7310 (TRS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-807-7310 (TRS: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-807-7310 (TRS: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-807-7310 (TRS: 711) تماس بگیرید.