Peak Care EPO Plan

School Employees Benefits Board (SEBB) Program
Start date: January 1, 2022

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

	Tahoma and MultiCare Connected Care Networks	
Monthly employee premium (emp) contribution Employee only / Employee+Spouse* / Employee+Child(ren) / Employee+Spouse*+Child(ren)	**$41 / $82 / $72 / $123**	
	In network	**Out of network**
Annual medical deductible per calendar year	$750 individual / $1,875 family	Not covered
Coinsurance	25%	
Out-of-pocket maximum (OOP max) Includes deductible, coinsurance, and copays	$3,500 individual / $7,000 family	
Office visit copay (deductible waived) Includes naturopathy services	$20 copay non-specialist / $40 copay specialist	
Urgent care	Deductible, then 25%	
Virtual care (deductible waived) 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: Physical, speech, occupational (45 days combined PCY); Neurodevelopmental (45 days PCY) Outpatient: Physical, speech, occupational (45 visits combined PCY); Neurodevelopmental (45 visits 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	$0	
Hearing Exam: 1 PCY Hardware	Exam: Covered at 100% Hardware: One hearing instrument per ear every 5 years. Deductible waived.	Exam: Not covered Hardware: One hearing instrument per ear every 5 years. Deductible waived.
Annual prescription deductible: PCY	$125 individual / $312 family	$125 individual / $312 family
Prescription drugs Retail and specialty: 30-day supply / Mail order: 90-day supply Preferred generic Preferred brand Preferred specialty (30-day supply; mail order only) Non-preferred drugs Drug list (view full E4 drug list at **premera.com/sebb**)	Applies to medical OOP max for in-network prescriptions. The member pays the difference 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

Choose a plan based on the county where you live or work. 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
- 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 (TRS: 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 benefits booklets.

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, 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. 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.

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

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

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