

Standard PPO Plan

School Employees Benefits Board (SEBB) Program

Start date: January 1, 2020



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 | Heritage Prime Network | |
|--|--|---|
| | \$22 / \$44 / \$39 / \$66 | |
| | In-network | Out-of-network |
| Annual medical deductible per calendar year (PCY) | \$1,250 / \$3,125 | \$2,000 / \$5,000 |
| Coinsurance | 20% | 50% |
| Out-of-pocket maximum (OOP max): Emp/Family Includes deductible, coinsurance, and copays. | \$5,000 / \$10,000 | Unlimited |
| Office visit copay Includes naturopathy services | \$20 non-specialist / \$40 specialist | Deductible, then 50% |
| Urgent care | Deductible, then 20% | |
| Virtual care General medical / dermatology Emergency care (secure chat) Behavioral health | \$5 copay \$5 copay \$20 copay | Not covered |
| Alternative care: Spinal manipulation: 12 visits PCY Acupuncture: 12 visits PCY Massage therapy: 12 visits PCY | Deductible, then 20% | Deductible, then 50% |
| Emergency services Emergency care (copay waived if directly admitted to an inpatient facility) Ambulance transportation (air and ground) | \$150 copay, then deductible, then 20% Deductible, then 20% | \$150 copay, then deductible, then 20% Deductible, then 20% |
| Hospitalization Inpatient and outpatient services Organ and tissue transplants | Deductible, then 20% | Deductible, then 50% |
| Maternity and newborn care | Deductible, then 20% | Deductible, then 50% |
| Mental health and substance use disorder services, including behavioral health Office visit Inpatient and outpatient hospital: mental/behavioral health | \$20 copay Deductible, then 20% | Deductible, then 50% Deductible, then 50% |
| 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 20% \$40 copay Deductible, then 20% | Deductible, then 50% |
| Laboratory services Includes x-ray, pathology, imaging/diagnostic, standard ultrasound Major imaging including MRI, CT, PET | Deductible, then 20% | Deductible, then 50% |
| Preventive and wellness services Screenings Exams and vaccinations | Plan covers at 100% | Not covered |
| Hearing Exam: 1 PCY Hardware | Plan covers at 100% \$1,000 covered every 3 calendar years | Deductible, then 50% \$1,000 covered every 3 calendar years |
| Annual prescription deductible: PCY | \$250 / \$750 | \$250 / \$750 |
| 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% 40% 50% E4 | Cost share, then 40% (to allowable amount) Not covered for mail order E4 |

*Or state-registered domestic partner

Premera Blue Cross Standard PPO health plan is available in these counties: Adams, Asotin, Benton, Chelan, Clallam, Columbia, Cowlitz, Ferry, Franklin, Garfield, Grant, Grays Harbor, Jefferson, King, Kitsap, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, and Yakima 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 20%, you pay 20% of the allowed amount and your plan pays the other 80%.

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

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.

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 комутування повідомлень: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ 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 ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-807-7310 (በስልክ ማገናኛ አገልግሎት: 711)።

XIYEEFFANNA: 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 تحويل الاتصالات للسمع 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).

ប្រែប្រួល: ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, ការបំប្រែភាសា គឺឥតគិតថ្លៃ។ ទូរស័ព្ទ 800-807-7310 (TRS: 711) ដើម្បីទទួលបានជំនួយ។

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.