

# Standard PPO Plan

School Employees Benefits Board (SEBB) Program

January 1, 2024 through December 31, 2024



BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

PCY = per calendar year; OOP = out-of-pocket

Monthly employee premium Employee only / Employee+Spouse* / Employee+Child(ren) / Employee+Spouse*+Child(ren)	Heritage Prime Network	
	\$64/\$128/\$112/\$192	
	In network	Out of network
<b>Annual medical deductible</b>	\$1,250 individual / \$3,125 family	\$2,000 individual / \$5,000 family
<b>Coinsurance</b>	20%	50%
<b>Out-of-pocket maximum (OOP max)</b> Includes deductible, coinsurance, and copays	\$5,000 individual / \$10,000 family	Unlimited
<b>Office visit copay</b> (deductible waived) Includes naturopathy services	\$25 copay nonspecialist (deductible waived) / \$50 copay specialist (deductible waived)	Deductible, then 50%
<b>Urgent care</b>	Deductible, then 20%	
<b>Virtual care</b> (deductible waived) General medical / dermatology Behavioral health	\$5 copay (deductible waived) \$25 copay (deductible waived)	Not covered
<b>Alternative care:</b> Spinal manipulation: 24 visits PCY Acupuncture: 24 visits PCY Massage therapy: 24 visits PCY	\$25 copay (deductible waived)	Deductible, then 50%
<b>Emergency services</b> 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%
<b>Hospitalization</b> Inpatient and outpatient services Organ and tissue transplants	Deductible, then 20%	Deductible, then 50%
<b>Maternity and newborn care</b>	Deductible, then 20%	Deductible, then 50%
<b>Mental health and substance use disorder services, including behavioral health</b> Office visit Inpatient and outpatient hospital: mental/behavioral health	\$25 copay (deductible waived) Deductible, then 20%	Deductible, then 50% Deductible, then 50%
<b>Rehabilitative and habilitative services and devices</b> 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 20% \$50 copay (deductible waived) Deductible, then 20%	Deductible, then 50%
<b>Laboratory services</b> Includes x-ray, pathology, imaging/diagnostic, standard ultrasound Major imaging including MRI, CT, PET	Deductible, then 20%	Deductible, then 50%
<b>Preventive and wellness services</b> Screenings Exams and vaccinations	\$0 (deductible waived)	Not covered
<b>Hearing</b> Exam: 1 PCY Hardware	Exam: Plan covers at 100% Hardware: One hearing instrument per ear, up to \$3,000 every 36 months (deductible waived)	Exam: Deductible, then 50% Hardware: One hearing instrument per ear, up to \$3,000 every 36 months (deductible waived).
<b>Annual prescription deductible:</b> PCY	\$250 individual / \$750 family	\$250 individual / \$750 family
<b>Prescription drugs</b> 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 <a href="https://premera.com/sebb">premera.com/sebb</a> )	Applies to medical OOP max for in-network prescriptions. The member pays the difference when requesting a brand-name drug. \$9 / \$18 copay (deductible waived) 30% 40% 50% E4	Cost share, then 40% (to allowed 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 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, Kittitas, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, and Yakima counties.

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# Understanding your health plan should be simple and easy

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

**Allowed amount:** The amount Premera Blue Cross 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. The allowed amount for an out-of-network provider is determined by Premera Blue Cross. In-network providers will not bill you for charges over the allowed amount.

If you receive services from an out-of-network 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. This is called balance billing.

**Coinsurance:** Your percentage of the cost for a service. With the exception of some services, 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.

**Cost Share:** The part of healthcare costs that a member pays, such as deductibles, coinsurance, and copay. It does not include monthly health plan bills, amounts balance billed by healthcare providers who are out of your plan network, or the cost of services not included in your plan.

**Deductible:** The amount you pay in medical costs before your health plan begins to pay. (The deductible does not apply to some services.) Amounts over the allowed amount for the service do not count toward the deductible.

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

**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.

**Urgent care:** Conditions that need treatment right away but are not severe or life threatening. Out-of-network urgent care is covered at deductible, then 50%.

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

## 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](https://premera.com/sebb).

Benefits are not provided for treatment, surgery, services, prescription 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 preapproval for coverage from your plan before you receive them, visit [premera.com/sebb](https://premera.com/sebb).

## Contact us

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

- Visit [premera.com/sebb](https://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 this plan. On our website, you can find the Summary of Benefits and Coverage (SBC) and benefits booklet.

## Notice of availability and nondiscrimination 800-807-7310 | TRS: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ ሙሉሪዎዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwonń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TRS: 711, Fax: 425-918-5592, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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>.