HMO Plan

School Employees Benefits Board (SEBB) Program
January 1, 2024 through December 31, 2024

PREMERA HMO
An Independent Licensee of the Blue Cross Blue Shield Association

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

	Sherwood HMO Network	
Monthly employee premium Employee only / Employee+Spouse* / Employee+Child(ren) / Employee+Spouse*+Child(ren)	**$20/$40/$35/$60**	
	In network	**Out of network**
Annual medical deductible per calendar year	$750 individual / $1,500 family	Not covered
Coinsurance	20%	
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	$10 copay primary care (deductible waived) / $40 copay specialist (deductible waived)	
Urgent care	$25 copay (deductible waived)	$25 copay (deductible waived)
Virtual care (deductible waived) General medical / dermatology Behavioral health	$5 copay (deductible waived) $10 copay (deductible waived)	Not covered
Alternative care Spinal manipulation: 24 visits PCY Acupuncture: 24 visits PCY Massage therapy: 24 visits PCY	$10 copay (deductible waived)	
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%	Not covered
Maternity and newborn care	Deductible, then 20%	
Mental health and substance use disorder services, including behavioral health Office visit Inpatient and outpatient hospital: mental/behavioral health	$10 copay (deductible waived) Deductible, then 20%	
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 20% $40 copay (deductible waived) Deductible, then 20%	
Laboratory services Basic includes x-ray, pathology, imaging/diagnostic, standard ultrasound Major imaging includes MRI, CT, PET	Basic: $75 copay Major: $150 copay	
Preventive and wellness services Screenings Exams and vaccinations	$0 (deductible waived)	
Hearing Exam: 1 PCY Hardware	Exam: Covered at 100% Hardware: One hearing instrument per ear, up to $3,000 every 36 months (deductible waived)	Exam: Not covered Hardware: One hearing instrument per ear, up to $3,000 every 36 months (deductible waived)
Annual prescription deductible: PCY	No Rx deductible	No Rx deductible
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. $9 / $18 copay $40 / $80 copay — / $75 copay 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 HMO health plan is available in these counties:
King, Pierce, Spokane, and Thurston counties.

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 HMO 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 HMO. 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**.

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 preapproval 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 HMO (Premera HMO) 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 HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO 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 HMO 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 HMO 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).
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Language Assistance

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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).

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