PREMERA EDUCATION PROGRAM

Medical Plans

Effective November 1, 2017

PCY = Per Calendar Year **OT** = Occupational Therapy
PT = Physical Therapy **Rx** = Prescription Drugs

Provider Network		EasyChoice A Heritage		EasyChoice B Heritage		Basic Heritage	
Copayments, Deductible, and Coinsurance		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Copayments							
Non-specialist Copay		$25*	50%	$30*	50%	$35*	50%
Specialist Copay		$35*	50%	$40*	50%	$50*	50%
Inpatient Copay (per person)		None		None		None	
Outpatient Surgery Copay		None		None		None	
ER Copay (waived if admitted)		$100		$150		$200	
Deductible							
Deductible PCY	Individual	$1,250	$2,000	$750	$1,500	$2,100	$2,500
	Family	$3,750	$6,000	$2,250	$4,500	$4,200	$5,000
Coinsurance							
Coinsurance (Coin)		20%	50%	25%	50%	30%	50%
Out-of-Pocket Maximum (OOPM) PCY** includes copays, deductible, and coinsurance	Individual	$4,000	No limit	$3,500	No limit	$6,600	No limit
	Family	$8,000	No limit	$7,000	No limit	$13,200	No limit
Covered Services		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits—Professional Care							
Medical and Naturopathic Office Visits unlimited **Spinal and Other Manipulations** 12 visits PCY (chiropractic) **Acupuncture** 12 visits PCY		$25*	50%	$30*	50%	$35*	50%
Preventive Care							
Exams/Vaccinations		$0*	Not covered	$0*	Not covered	$0*	Not covered
Preventive Screenings (includes mammography and colon health screenings)		$0*	50%	$0*	50%		50%
Diagnostic Services							
Diagnostic Imaging/Laboratory		Paid in full to $1,000 then Ded+Coin		Ded + Coin		Ded + Coin	
Hospital/Facility Care							
Outpatient **Inpatient**		Ded + Coin		Ded + Coin		Ded + Coin	
Maternity—Prenatal Care		Covered in full	Ded + Coin	Covered in full	Ded + Coin	Covered in full	Ded + Coin
Maternity—Delivery/Postnatal Care (newborns have their own deductibles and coinsurance)		Ded + Coin		Ded + Coin		Ded + Coin	
Emergency Care							
Professional/Facility		ER Copay + Ded + Coin		ER Copay + Ded + Coin		ER Copay + Ded + Coin	
Ambulance (air and ground)		Ded + Coin		Ded + Coin		Ded + Coin	
Other Services							
Mental Health Outpatient unlimited visits		$25*	50%	$30*	50%	$35*	50%
Mental Health Inpatient unlimited days		Ded + Coin		Ded + Coin		30%	50%
Rehabilitation Outpatient A and Basic: 30 visits PCY; B: 45 visits PCY (PT, Massage, Speech, OT)		$35*	50%	$40*	50%	$50*	50%
Rehabilitation Inpatient A and Basic: 30 days PCY; B: 45 days PCY		Ded + Coin		Ded + Coin		30%	50%
Prescription Drugs (participating pharmacies)		Generic / Preferred brand-name / Non-preferred brand-name					
Rx Deductible per person PCY		$500 (waived for generics)		$250 (waived for generics)		$750 individual $1,500 family	
Rx Out-of-Pocket Maximum** includes Rx copays, Rx deductible, and Rx coinsurance		Shared with medical OOPM		Shared with medical OOPM		Shared with medical OOPM	
Retail Cost Share up to 30-day supply		$10 / 30% / 30%		$5 / $30 / $45		$15 / $30 / $50	Not covered
Mail Order Cost Share up to 90-day supply		$20 / 30% / 30%		$10 / $75 / $112		$30 / $60 / $100	
Specialty Drug Cost Share up to 30-day supply		30%		30%		30%	
Drug List		A-2		B-4		B-4	
Symetra Life and AD&D Insurance		$25,000 Term Life and AD&D for employee only					

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

* Not subject to the calendar year deductible

** Once the out-of-pocket maximum is met, covered in-network services are paid at 100% of allowable charges for the remainder of the calendar year. There is no out-of-pocket maximum for Plans 5, EasyChoice A, B, and Basic for out-of-network services.

037550 (08-2017)

Premera Blue Cross : EasyChoice A Plan

Coverage for: Individual or Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-756-0798 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-0798 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,250 Individual / $3,750 Family. Out-of-network: $2,000 Individual / $6,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to copayments, prescription drugs and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. For pharmacy: $500 Individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $4,000 Individual / $8,000 Family Out-of-network: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-855-756-0798 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	50% coinsurance	None
	Specialist visit	$35 copayment	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	First $1,000 no charge, then 20% coinsurance	First $1,000 no charge, then 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	First $1,000 no charge, then 20% coinsurance	First $1,000 no charge, then 50% coinsurance	Prior authorization recommended for some outpatient imaging tests. Penalty for out-of-network: no penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://client.formularynavigator.com/Search.aspx?siteCode=6065073448.	Generic drugs	$10 copayment (retail), $20 copayment (mail)	Not covered	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Pharmacy deductible waived for generics. Prior authorization recommended for some drugs.
	Preferred brand drugs	30% coinsurance	Not covered	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Pharmacy deductible applies. Prior authorization recommended for some drugs.
	Non-preferred brand drugs	30% coinsurance	Not covered	
	Specialty drugs	30% coinsurance	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Pharmacy deductible applies. Prior authorization recommended for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior authorization recommended for some services. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copayment + 20% coinsurance	$100 copayment + 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Hospital-based: $100 copayment + 20% coinsurance Freestanding center: $25 copayment Non-Specialist, $35 copayment Specialist	Hospital-based: $100 copayment + 20% coinsurance Freestanding center: 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $25 copayment Facility: 20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
If you are pregnant	Office visits	No charge	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $35 copayment Inpatient: 20% coinsurance	50% coinsurance	Limited to 30 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Habilitation services	Outpatient: $35 copayment Inpatient: 20% coinsurance	50% coinsurance	Limited to 30 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 30 days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization recommended to buy some medical equipment over $500. Penalty for out-of-network: no penalty.
	Hospice services	20% coinsurance	50% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Assisted fertilization treatment	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-562-6900 for the state insurance department, or the insurer at 1-855-756-0798. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-855-756-0798.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-756-0798.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-756-0798.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-855-756-0798.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-756-0798.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,250
Specialist copay	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$80
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,640

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,250
Specialist copay	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$700
Copayments	$600
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,820

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,250
Specialist copay	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,300
Copayments	$200
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,560

043240 (08-15-2017)

Premera Blue Cross : EasyChoice B Plan

Coverage for: Individual or Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-756-0798 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-0798 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $750 Individual / $2,250 Family. Out-of-network: $1,500 Individual / $4,500 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to copayments, prescription drugs and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. For pharmacy: $250 Individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $3,500 Individual / $7,000 Family Out-of-network: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-855-756-0798 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment	50% coinsurance	None
	Specialist visit	$40 copayment	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	Prior authorization recommended for some outpatient imaging tests. Penalty for out-of-network: no penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://client.formularynavigator.com/Search.aspx?siteCode=1961494599.	Generic drugs	$5 copayment (retail), $10 copayment (mail)	Not covered	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Pharmacy deductible waived for generics. Prior authorization recommended for some drugs.
	Preferred brand drugs	$30 copayment (retail), $75 copayment (mail)	Not covered	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Pharmacy deductible applies. Prior authorization recommended for some drugs.
	Non-preferred brand drugs	$45 copayment (retail), $112 copayment (mail)	Not covered	
	Specialty drugs	30% coinsurance	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Pharmacy deductible applies. Prior authorization recommended for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Prior authorization recommended for some services. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copayment + 25% coinsurance	$150 copayment + 25% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	Hospital-based: $150 copayment + 25% coinsurance Freestanding center: $30 copayment Non-Specialist, $40 copayment Specialist	Hospital-based: $150 copayment + 25% coinsurance Freestanding center: 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 copayment Facility: 25% coinsurance	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
If you are pregnant	Office visits	No charge	50% coinsurance	None
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $40 copayment Inpatient: 25% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 45 inpatient days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Habilitation services	Outpatient: $40 copayment Inpatient: 25% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 45 inpatient days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Skilled nursing care	25% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Durable medical equipment	25% coinsurance	50% coinsurance	Prior authorization recommended to buy some medical equipment over $500. Penalty for out-of-network: no penalty.
	Hospice services	25% coinsurance	50% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Assisted fertilization treatment	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-562-6900 for the state insurance department, or the insurer at 1-855-756-0798. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-855-756-0798.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-756-0798.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-756-0798.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-855-756-0798.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-756-0798.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$0
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,660

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,120

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,300

043241 (08-15-2017)

Premera Blue Cross : Basic Plan

Coverage for: Individual or Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-756-0798 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-0798 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,100 Individual / $4,200 Family. Out-of-network: $2,500 Individual / $5,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to copayments, prescription drugs and services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. For pharmacy: $750 Individual/$1,500 Family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $6,600 Individual / $13,200 Family Out-of-network: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-855-756-0798 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copayment	50% coinsurance	None
	Specialist visit	$50 copayment	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Prior authorization recommended for some outpatient imaging tests. Penalty for out-of-network: no penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://client.formularynavigator.com/Search.aspx?siteCode=1961494599.	Generic drugs	$15 copayment (retail), $30 copayment (mail)	Not covered	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Pharmacy deductible applies. Prior authorization recommended for some drugs.
	Preferred brand drugs	$30 copayment (retail), $60 copayment (mail)	Not covered	
	Non-preferred brand drugs	$50 copayment (retail), $100 copayment (mail)	Not covered	
	Specialty drugs	30% coinsurance	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Pharmacy deductible applies. Prior authorization recommended for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Prior authorization recommended for some services. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copayment + 30% coinsurance	$200 copayment + 30% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	Hospital-based: $200 copayment + 30% coinsurance Freestanding center: $35 copayment Non-Specialist, $50 copayment Specialist	Hospital-based: $200 copayment + 30% coinsurance Freestanding center: 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $35 copayment Facility: 30% coinsurance	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
If you are pregnant	Office visits	No charge	50% coinsurance	None
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $50 copayment Inpatient: 30% coinsurance	50% coinsurance	Limited to 30 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Habilitation services	Outpatient: $50 copayment Inpatient: 30% coinsurance	50% coinsurance	Limited to 30 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 30 days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Durable medical equipment	30% coinsurance	50% coinsurance	Prior authorization recommended to buy some medical equipment over $500. Penalty for out-of-network: no penalty.
	Hospice services	30% coinsurance	50% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Assisted fertilization treatment	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-562-6900 for the state insurance department, or the insurer at 1-855-756-0798. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-855-756-0798.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-756-0798.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-756-0798.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-855-756-0798.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-756-0798.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,100
Specialist copay	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,100
Copayments	$100
Coinsurance	$3,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,360

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,100
Specialist copay	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,920

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,100
Specialist copay	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,200
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,800

043242 (08-15-2017)