Standard PPO Plan

School Employees Benefits Board (SEBB) Program
Start date: January 1, 2021

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

Monthly employee premium (emp) contribution Employee only / Employee+Spouse* / Employee+Child(ren) / Employee+Spouse*+Child(ren)	**Heritage Prime Network** **$28 / $56 / $49 / $84**	
	In network	**Out of network**
Annual medical deductible per calendar year (PCY)	$1,250 individual / $3,125 family	$2,000 individual / $5,000 family
Coinsurance	20%	50%
Out-of-pocket maximum (OOP max) Includes deductible, coinsurance, and copays	$5,000 individual / $10,000 family	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: 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, 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	Exam: Plan covers at 100% Hardware: One hearing instrument per ear every 5 years. Deductible waived.	Exam: Ded, then 50% Hardware: One hearing instrument per ear every 5 years. Deductible waived.
Annual prescription deductible: PCY	$250 individual / $750 family	$250 individual / $750 family
Prescription drugs Retail and specialty: 30-day supply / Mail order: 90-day supply Preferred generic Preferred brand Preferred specialty (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 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

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, 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 (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 Certificate of Coverage (CoC) documents.