Premera Blue Cross : Your Choice NGF

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 1-800-722-1471 (TTY: 711) 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-722-1471 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 Individual / $750 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 Preventive care, 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: $100 Individual/$300 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: $2,000 Individual / $4,000 Family, Out-of-network: Not Applicable	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, penalties for failure to obtain prior authorization for services, 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 1-800-722-1471 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	15% coinsurance	40% coinsurance	None
	Specialist visit	15% coinsurance	40% 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)	15% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	Prior authorization required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/055090_2024.pdf	Generic drugs	10% coinsurance (retail), $10 copay/prescription (mail)	10% coinsurance + 40% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply for retail/mail. Member cost limits for generic and preferred brand drugs: $75 max for up to a 30 day supply $150 max for up to a 60 day supply $225 max for up to a 90 day supply No charge for specific preventive drugs. Pharmacy deductible does not apply for generic drugs. Pharmacy deductible applies for preferred and non-preferred brand drugs. Prior authorization required for some drugs.
	Preferred brand drugs	30% coinsurance (retail), $50 copay/prescription (mail)	30% coinsurance + 40% coinsurance (retail), not covered (mail)	
	Non-preferred brand drugs	50% coinsurance (retail), $100 copay/prescription (mail)	50% coinsurance + 40% coinsurance (retail), not covered (mail)	
	Specialty drugs	Generic: 10% coinsurance (deductible does not apply) Pref. Brand: 30% coinsurance Non-Pref. Brand: 50% coinsurance	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Pharmacy deductible applies. Prior authorization required for some drugs.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	Prior authorization required for some services. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	15% coinsurance (deductible does not apply)	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 copay/visit + 15% coinsurance	$75 copay/visit + 15% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	Hospital-based: $75 copay/visit + 15% coinsurance Freestanding center: 15% coinsurance	Hospital-based: $75 copay/visit + 15% coinsurance Freestanding center: 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per day up to $600 maximum + 15% coinsurance	40% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Physician/surgeon fees	15% coinsurance (deductible does not apply)	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	40% coinsurance	None
	Inpatient services	$200 copay per day up to $600 maximum + 15% coinsurance	40% coinsurance	Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
If you are pregnant	Office visits	15% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$200 copay per day up to $600 maximum + 15% coinsurance	40% coinsurance	

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	15% coinsurance (deductible does not apply)	40% coinsurance	None
	Rehabilitation services	Outpatient: 15% coinsurance Inpatient: $200 copay per day up to $600 maximum + 15% coinsurance	40% coinsurance	Limited to 60 outpatient visits per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Habilitation services	Outpatient: 15% coinsurance Inpatient: $200 copay per day up to $600 maximum + 15% coinsurance	40% coinsurance	Limited to 60 outpatient visits per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Skilled nursing care	$200 copay per day up to $600 maximum + 15% coinsurance	40% coinsurance	Limited to 150 days per calendar year. Prior authorization required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to $1,500 per stay.
	Durable medical equipment	15% coinsurance (deductible does not apply)	40% coinsurance	Prior authorization required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to $1,500 per occurrence.
	Hospice services	No charge	40% coinsurance	Limited to 240 respite hours - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	15% coinsurance (deductible does not apply)	15% coinsurance (deductible does not apply)	Limited to one exam per calendar year (under age 19).
	Children's glasses	No charge	No charge	Frames and lenses: Limited to one pair per calendar year (under age 19).
	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.)		
• Cosmetic surgery	• Infertility treatment	• Private-duty nursing
• Dental care (Adult)	• 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.
• Bariatric surgery	• Hearing aids	
• Chiropractic care or other spinal manipulations		• Routine eye care (Adult)

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: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY: 711. 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 1-800-562-6900 or TTY: 711, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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 1-800-722-1471.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

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	**$250**
Specialist coinsurance	**15%**
Hospital (facility) copay	**$200**
Other coinsurance	**15%**

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	$300
Copayments	$400
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**15%**
Hospital (facility) copay	**$200**
Other coinsurance	**15%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles *	$350
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,670**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

The plan's overall deductible	**$250**
Specialist coinsurance	**15%**
Hospital (facility) copay	**$200**
Other coinsurance	**15%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles *	$300
Copayments	$80
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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, sex, gender identity, or sexual orientation. 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, 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, TTY: 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). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 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 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 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。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.