Premera BC: AWB Plan D 750 $750 Deductible (GF)

Summary of Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 12/01/2014

Coverage for: Individual or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.premera.com or by calling 1-800-722-1471.

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. Does not apply to **copays**, **prescription drugs** and services listed below as "No charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$3,250** Individual / **$9,750** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premium**, balance-billed charges, **prescription drugs**, penalties for failure to obtain **prior authorization** for services, and health care this plan doesn't cover.bj	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.premera.com or call 1-800-722-1471.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-722-1471 or TDD/TTY 1-800-842-5357 or visit us at www.premera.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-722-1471 or TDD/TTY 1-800-842-5357 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay	50% coinsurance	——————none——————
	Specialist visit	$30 copay	50% coinsurance	——————none——————
	Other practitioner office visit	$30 copay	50% coinsurance	Spinal manipulations limited to 12 visits per calendar year, Acupuncture limited to 12 visits per calendar year
	Preventive care / screening / immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior authorization is required for certain outpatient imaging tests. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.premera.com.	Generic drugs	$15 copay (retail), $37 copay (mail)	$15 copay + 40% coinsurance (retail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization is required for certain drugs.
	Preferred brand drugs	$30 copay (retail), $75 copay (mail)	$30 copay + 40% coinsurance (retail)	
	Non-preferred brand drugs	$50 copay (retail), $125 copay (mail)	$50 copay + 40% coinsurance (retail)	
	Specialty drugs	Generic: $15 copay Pref. Brand: $30 copay Non-Pref. Brand: $50 copay	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization is required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior authorization is required for certain outpatient services. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay + 20% coinsurance	$100 copay + 20% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$30 copay	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization is required for all planned inpatient admissions. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay	50% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Prior authorization is required for all planned inpatient admissions. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Substance use disorder outpatient services	$30 copay	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Prior authorization is required for all planned inpatient admissions. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	Coverage is limited to the subscriber or enrolled spouse.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Coverage is limited to the subscriber or enrolled spouse.
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: $30 copay Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization is required for all planned inpatient admissions. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Habilitation services	Outpatient: $30 copay Inpatient: 20% coinsurance	50% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Neurodevelopmental therapy limited to members under age 7. Prior authorization is required for all planned inpatient admissions. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Prior authorization is required for inpatient admissions to skilled nursing facilities. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization is required for purchase of some durable medical equipment over $500. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Hospice service	20% coinsurance	50% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care or other spinal manipulations
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-722-1471**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at **1-800-722-1471**. You can contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at **1-800-562-6900**. Additionally, a consumer assistance program can help you file your appeal. Contact **1-800-562-6900**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,220
- **Patient pays** $2,320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$800
Copays	$20
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$2,320**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$800
Copays	$800
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,880**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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