# Premera Blue Cross: WEA Select EasyChoice A

**Coverage Period: 11/1/2014 - 10/31/2015**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for: All Coverage Tiers** | **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/wea or by calling 1-800-932-9221.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** person/**$3,000** family in-network or **$2,000** person/**$6,000** family out-of-network. Does not apply to in-network preventive care, in-network office visits or generic drugs. | 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?** | Yes. **$500** person per year for non-generic drugs. | 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. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. Medical: **$4,000** person **/$12,000** family in-network or **unlimited** out-of-network. Prescription drugs: **$5,000** person per year. | 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?** | Medical: Premiums, balance-billed charges, prescription drug costs and care not covered by this plan. Prescription drugs: Premiums and drugs not covered by this plan. | 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. Heritage Provider Network. Go to www.premera.com/wea or call 1-800-932-9221. | 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**. |

- **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**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay/visit | 50% coinsurance | Deductible waived in-network. |
| | Specialist visit | $15 copay/visit | 50% coinsurance | Deductible waived in-network. |
| | Other practitioner office visit | $15 copay/visit | 50% coinsurance | Deductible waived in-network. |
| | Preventive care/screening/immunization | No charge | Screenings: 50% coinsurance | Deductible waived in-network. Exams and Immunizations not covered out-of-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Covered in full to $1,000; then 20% coinsurance | Covered in full to $1,000; then 50% coinsurance | Deductible waived for first $1,000 in covered diagnostic tests and imaging. |
| | Imaging (CT/PET scans, MRIs) | Covered in full to $1,000; then 20% coinsurance | Covered in full to $1,000; then 50% coinsurance | Prior authorization is required for certain outpatient imaging tests. Deductible waived for first $1,000 in covered imaging and diagnostic tests. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.premera.com/wea | Generic drugs | $0 (retail or mail order) | Not covered | Deductible waived. No cost share for Generic drugs. Covers up to a 30-day supply retail; up to a 90-day supply mail order. Not covered out-of-network. |
| | Preferred brand drugs | 30% coinsurance (retail);<br>25% coinsurance (mail order) | Not covered | Covers up to a 30-day supply retail; up to a 90-day supply mail order. $500 deductible/person/year. Not covered out-of-network. |
| | Non-preferred brand drugs | 30% coinsurance (retail);<br>25% coinsurance (mail order) | Not covered | Covers up to a 30-day supply retail; up to a 90-day supply mail order. $500 deductible/person/year. Not covered out-of-network. |
| | Specialty drugs | 30% coinsurance | Not covered | Covers up to a 30-day supply. $500 deductible/person/year. Not covered out-of-network. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Prior authorization is required for certain outpatient services. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | $100 copay/visit<br>20% coinsurance | $100 copay/visit<br>20% coinsurance | Copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ——————none—————— |
| | Urgent care | $15 copay/visit | 50% coinsurance | Deductible waived in-network. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Prior authorization is required for all planned inpatient stays. |
| | Physician/surgeon fee | 20% coinsurance | 50% coinsurance | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $15 copay/visit | 50% coinsurance | Deductible waived in-network. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 50% coinsurance | Prior authorization is required for all planned inpatient stays. |
| | Substance use disorder outpatient services | $15 copay/visit | 50% coinsurance | Deductible waived in-network. |
| | Substance use disorder inpatient services | 20% coinsurance | 50% coinsurance | Prior authorization is required for all planned inpatient stays. |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 50% coinsurance | ——————none—————— |
| | Delivery and all inpatient services | 20% coinsurance | 50% coinsurance | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Up to 130 visits per year.<br>Custodial care not covered. |
| | Rehabilitation services | Inpatient- 20% coinsurance<br>Outpatient - $15 copay/visit. | Inpatient - 50% coinsurance<br>Outpatient - 50% coinsurance | Inpatient- Up to 30 days per year.<br>Outpatient- Up to 30 visits per year; deductible waived in-network. |
| | Habilitation services | Inpatient- 20% coinsurance<br>Outpatient - $15 copay/visit | Inpatient - 50% coinsurance<br>Outpatient - 50% coinsurance | Inpatient- Up to 30 days per year.<br>Outpatient- Up to 30 visits per year; deductible waived in-network |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Up to 30 days per year.<br>Prior authorization is required.<br>Custodial care not covered. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Prior authorization is required for purchase of some durable medical equipment over $500. |
| | Hospice service | 20% coinsurance | 50% coinsurance | Up to 240 hours of respite care; 10 days of inpatient hospice care. |
| **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 & hardware (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 (12 visits per year)
- Chiropractic care (12 visits per year)
- 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 1-800-932-9221. 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**. For questions about your rights, this notice, or assistance, you can contact: 1-800-932-9221 or visit www.premera.com/wea.

Other resources to help you:
Washington Consumer Assistance Program
Office of the Washington Insurance Commissioner
5000 Capitol Blvd
Tumwater, WA 98501

Phone: 1-800-562-6900
On Line: www.insurance.wa.gov

## 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 1-800-932-9221.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-932-9221.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-932-9221.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-932-9221.

*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** $5,040
- **Patient pays** $2,500

**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 | $1,000 |
| Copays | $0 |
| Coinsurance | $1,300 |
| Limits or exclusions | $200 |
| **Total** | **$2,500** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,040
- **Patient pays** $1,360

**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 | $1,000 |
| Copays | $200 |
| Coinsurance | $80 |
| Limits or exclusions | $80 |
| **Total** | **$1,360** |

# 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.

# Glossary of Health Coverage and Medical Terms

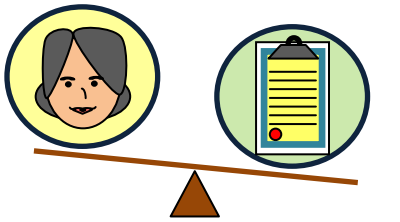
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

## Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

## Appeal
A request for your health insurer or plan to review a decision or a grievance again.

## Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

## Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

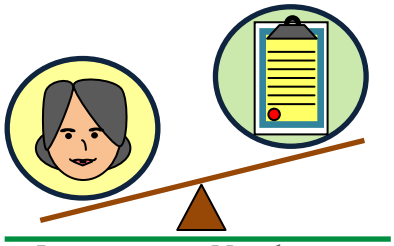


(See page 4 for a detailed example.)

## Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

## Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

## Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation
Ambulance services for an emergency medical condition.

## Emergency Room Care
Emergency services you get in an emergency room.

## Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.


OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

## Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

## Grievance
A complaint that you communicate to your health insurer or plan.

## Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

## Home Health Care
Health care services a person receives at home.

## Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

## Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

## In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

## In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

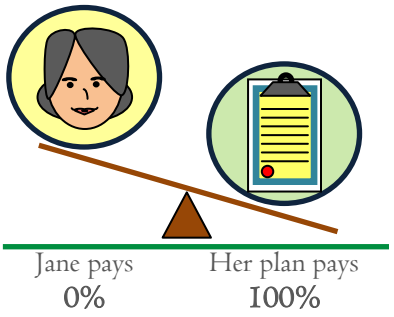
## Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

## Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

## Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

## Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

## Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

## Out-of-Pocket Limit



The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

(See page 4 for a detailed example.)

## Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

## Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

## Prescription Drugs
Drugs and medications that by law require a prescription.

## Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

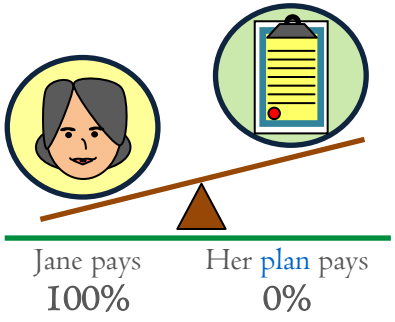
## Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

# How You and Your Insurer Share Costs - Example

**Jane's Plan Deductible:** $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

***January 1st***
*Beginning of Coverage Period*

***December 31st***
*End of Coverage Period*

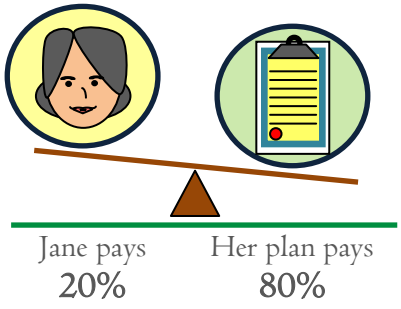



**Jane hasn't reached her $1,500 deductible yet**

Her plan doesn't pay any of the costs.

**Office visit costs:** $125
**Jane pays:** $125
**Her plan pays:** $0

more costs

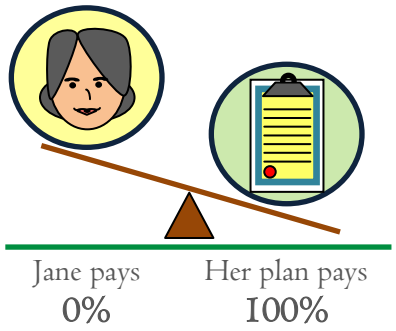



**Jane reaches her $1,500 deductible, co-insurance begins**

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

**Office visit costs:** $75
**Jane pays:** 20% of $75 = $15
**Her plan pays:** 80% of $75 = $60

more costs




**Jane reaches her $5,000 out-of-pocket limit**

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

**Office visit costs:** $200
**Jane pays:** $0
**Her plan pays:** $200