Fred Hutchinson Cancer Center : Plan B – Heritage Prime Network

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?	In-network: $450 Individual / $1,350 Family. Out-of-network: $650 Individual / $1,950 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $1,750 Individual / $5,250 Family, Out-of-network: $4,000 Individual / $12,000 Family	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 1-800-722-1471 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	$25 copay/visit	30% coinsurance	None
	Specialist visit	$25 copay/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	Preventive care/screening: Not covered. Immunization covered in full: 30% coinsurance for administrative costs of immunization.	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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% 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 https://www.premera.com/documents/052149_2024.pdf	Preferred generic drugs	$10 copay/prescription (retail), $20 copay/prescription (mail)	$10 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail), Retail pharmacies: one copay for each 30 day supply. No charge for specific preventive drugs. Prior authorization recommended for some drugs.
	Preferred brand drugs	$30 copay/prescription (retail), $60 copay/prescription (mail)	$30 copay/prescription + 40% coinsurance (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail), Retail pharmacies: one copay for each 30 day supply. Prior authorization recommended for some drugs.
	Preferred specialty drugs	$50 copay/prescription	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs. SaveonSP affects your cost share for certain drugs. See www.premera.com/saveonsp for more information.
	Non-preferred generic drugs Non-preferred brand drugs Non-preferred specialty drugs	Non-pref. generic: 30% coinsurance Non-pref. brand: 30% coinsurance Non-pref. specialty: 30% coinsurance	Non-pref. generic: 30% coinsurance + 40% coinsurance (retail), not covered (mail) Non-pref. brand: 30% coinsurance + 40% coinsurance (retail), not covered (mail) Non-pref. specialty: Not covered	Non-pref. generic and non-pref. brand: Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Non-pref. specialty drugs: Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization recommended for some drugs. SaveonSP affects your cost share for certain drugs. See www.premera.com/saveonsp for more information.

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)	10% coinsurance	30% coinsurance	Prior authorization recommended for some services. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit + 10% coinsurance	$150 copay/visit + 10% coinsurance	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	Hospital-based: $150 copay/visit + 10% coinsurance Freestanding center: $25 copay/visit	Hospital-based: $150 copay/visit + 10% coinsurance Freestanding center: 30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $25 copay/visit Facility: 10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
If you are pregnant	Office visits	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	Limited to 130 visits per calendar year
	Rehabilitation services	Outpatient: $25 copay/visit Inpatient: 10% coinsurance	30% coinsurance	Limited to 60 outpatient visits per calendar year, limited to 60 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Habilitation services	Outpatient: $25 copay/visit Inpatient: 10% coinsurance	30% coinsurance	Limited to 60 outpatient visits per calendar year, limited to 60 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 180 days per calendar year. Prior authorization recommended for all planned inpatient stays. Penalty for out-of-network: no penalty.
	Durable medical equipment	10% coinsurance	30% coinsurance	Prior authorization recommended to buy some medical equipment. Penalty for out-of-network: no penalty.
	Hospice services	10% coinsurance	30% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 12 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	$25 copay/visit	$25 copay/visit	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.)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult)	• Infertility treatment • Long-term care	• Private-duty nursing • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care or other spinal manipulations	• Foot care • Hearing aids	• Non-emergency care when traveling outside the U.S. • 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 1-800-722-1471 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	**$450**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$450
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,720**

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

The plan's overall deductible	**$450**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$200
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$450**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$450
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

Discrimination is Against the Law

Premera Blue Cross (Premera) complies 1Mth 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 1Mth disabilities to communicate effectively 1Mth us, such as qualified sign language interpreters and witten 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 witten 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 1Mth Civil Rights Coordinator-Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free 855-332-4535, Fax 425-918-5592, TTY 711, Email AppealsDepartmentlnguiries@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 \/11th the US 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/portalAobby.jsf, or by mail or phone at US 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/filelindex.html. You can also file a civil rights complaint 1Mth the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https//wwwinsurance.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

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

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Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur VerfUgung. Rufnummer 800-722-1471 (TTY 711). tuos1 u: tj' o Ifl !JCO W ;J o, muu:5mutjoeJC!i]BO IJW ;J , to.iuc J.i , CCJJ)Jj)l,JBjJ71))1fl IJ.1IIJ6 800-722-1471 (TTY 711). ATANSYON Si w pale Krey6l Ayisyen, gen sevis ed pou lang ki disponib gratis pou au. Rele 800-722-1471 (TTY 711).

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

UWAGA Jezeli m6wisz po polsku, mozesz skorzystac z bezp!atnej pomocy j zykowej. Zadzwon pod numer 800-722-1471 (TTY 711).

ATENCAO Se fala portugues, enoontram-se disponiveis servigos linguisticos, gratis Ligue para 800-722-1471 (TTY 711).

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

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