Microsoft: Access HSP

Coverage for: Individual or Family | **Plan Type:** High-Deductible

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 1-800-676-1411 (TTY: 711) or visit us at aka.ms/benefits. 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 1-800-676-1411 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,750 Employee Only $3,500 Employee + 1 $4,375 Employee + 2 Doesn't apply to preventive care	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care 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?	Yes. $2,750 Employee only $5,500 Employee + 1 $6,875 Employee + 2 Out-of-network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services.
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 **aka.ms/benefits or call 1-800-676-1411** 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	10% coinsurance	10% coinsurance	None
	Specialist visit	10% coinsurance	10% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	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 use an out-of-network provider, you may be responsible for balance billing.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	Prior authorization is recommended for some outpatient imaging tests.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available here	Generic drugs	10% coinsurance	10% coinsurance	Retail up to a 30-day supply/generic maintenance up to 90 days. Mail order up to 90-day supply. Preventive generic and single source brand drugs on the Preventive Drug List are covered in full and the deductible does not apply. Prior authorization is required for some drugs.
	Preferred brand drugs	10% coinsurance	10% coinsurance	Retail up to a 30-day supply / mail order up to a 90-day supply. Prior authorization is required for some drugs.
	Non-preferred brand drugs	10% coinsurance	10% coinsurance	
	Specialty drugs	10% coinsurance	Not Covered	Covers up to a 30-day supply. Only covered at specific contracted specialty pharmacies. Prior authorization is required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	Prior authorization is recommended for some services.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	Prior authorization is recommended for some services.
	Emergency room care	10% coinsurance	10% coinsurance	None

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 immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	10% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	Prior authorization is recommended for all planned inpatient admissions.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	Prior authorization is recommended for all planned inpatient admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	10% coinsurance	None
	Inpatient services	10% coinsurance	10% coinsurance	Prior authorization is recommended for all planned inpatient admissions.
If you are pregnant	Office visits	10% coinsurance	10% 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	10% 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 facility services	10% coinsurance	10% 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).

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	10% coinsurance	None
	Rehabilitation services	10% coinsurance	10% coinsurance	Includes physical therapy, speech therapy, and occupational therapy. Outpatient services limited to one hour per specialty per day.
	Habilitation services	10% coinsurance	10% coinsurance	Includes physical therapy, speech therapy, and occupational therapy. Outpatient services limited to one hour per specialty per day.
	Skilled nursing care	10% coinsurance	10% coinsurance	Prior authorization is recommended for all planned inpatient stays or partial hospital care services. 120-day limit.
	Durable medical equipment	10% coinsurance	10% coinsurance	None
	Hospice services	10% coinsurance	10% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Elective Plan Option

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 (except as covered under the Reconstructive Surgery Benefit)
- Long-term care
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Infertility treatment
- Bariatric surgery
- Chiropractic care or other spinal manipulations
- Dental care (Adult)
- Routine foot care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss program

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. 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 1-800-676-1411 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 1-800-676-1411.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-676-1411.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-676-1411.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-676-1411.

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	$1,750
Specialist coinsurance	10%
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	$1,750
Copayments	$0
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,750**

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

The plan's overall deductible	$1,750
Specialist coinsurance	10%
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	$1750
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,135**

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

The plan's overall deductible	$1,750
Specialist coinsurance	10%
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	$1,750
Copayments	$0
Coinsurance	$105
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,855**

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.|

An Independent Licensee of the Blue Cross Blue Shield Association
037397 (07-05-2024)

PREMERA | BLUE CROSS