Sterling Plans - July 1, 2021 through June 30, 2022

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

	Sterling 250	Sterling 500	Sterling 750	Sterling 1000	Sterling 1500	Sterling 2000	Sterling 2500	Sterling 3000	Sterling 4000	Sterling 5000
Deductible* (individual/family)	$250 / $750	$500 / $1,500	$750 / $2,250	$1,000 / $3,000	$1,500 / $4,500	$2,000 / $6,000	$2,500 / $7,500	$3,000 / $9,000	$4,000 / $12,000	$5,000 / $13,100
Out-of-Pocket Maximum* (deductible included)	$3,750 / $11,250	$5,500 / $14,300	$6,000 / $14,300	$6,000 / $14,300	$6,000 / $14,300	$7,000 / $14,300	$7,000 / $14,300	$7,000 / $14,300	$7,000 / $14,300	$7,000 / $14,300
Plan Benefits										
Coinsurance										
In-Network	20%	20%	20%	20%	20%	20%	20%	20%	30%	30%
Out-of-Network	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Office Visit Cost Share										
In-Network	$30 copay	$30 copay	$35 copay	$35 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Preventive Office Visit/Immunizations										
In-Network	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Preventive Professional Diagnostic Imaging and Laboratory Services										
In-Network	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Other Professional Diagnostic Imaging										
In-Network	20%, deductible waived	20%, deductible waived	20%, deductible waived	20%, deductible waived	20%, deductible waived	20%, deductible waived	20%, deductible waived	20%, deductible waived	30%, deductible waived	30%, deductible waived
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Rehab										
Inpatient Facility	30 days PCY	30 days PCY	30 days PCY	30 days PCY	30 days PCY	30 days PCY	30 days PCY	30 days PCY	30 days PCY	30 days PCY
In-Network	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient Care (non chronic conditions)	45 visits PCY	45 visits PCY	45 visits PCY	45 visits PCY	45 visits PCY	45 visits PCY	45 visits PCY	45 visits PCY	45 visits PCY	45 visits PCY
In-Network	$30 copay	$30 copay	$35 copay	$35 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Inpatient Facility										
In-Network	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient Facility										
In-Network	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Emergency Care (copay waived if admitted to inpatient facility)	$200 copay, then 20% after deductible	$200 copay, then 20% after deductible	$200 copay, then 20% after deductible	$200 copay, then 20% after deductible	$200 copay, then 20% after deductible	$200 copay, then 20% after deductible	$200 copay, then 20% after deductible	$200 copay, then 20% after deductible	$200 copay, then 30% after deductible	$200 copay, then 30% after deductible
Manipulations -Spinal and other (12 visits PCY)										
In-Network	$30 copay	$30 copay	$35 copay	$35 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Acupuncture (12 visits PCY)										
In-Network	$30 copay	$30 copay	$35 copay	$35 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay
Out-of-Network	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Annual Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pharmacy (In-Network)										
Retail Cost Shares	$10/$30/$60/$250	$10/$30/$60/$250	$10/$30/$60/$250	$10/$30/$60/$250	$10/$40/$80/$250	$10/$40/$80/$250	$10/$40/$80/$250	$10/$50/$100/$250	$10/$50/$100/50%	$10/$50/$100/50%
Mail Cost Shares	$25/$75/$150/$250	$25/$75/$150/$250	$25/$75/$150/$250	$25/$75/$150/$250	$25/$100/$200/$250	$25/$100/$200/$250	$25/$100/$200/$250	$25/$125/$250/$250	$25/$125/$250/50%	$25/$125/$250/50%

This benefit summary is not a contract or a complete explanation of covered services, exclusions, limitations, or reductions. Please refer to the benefit highlights and booklets for additional information.

*Deductibles and Out-of-Pocket Maximums shown are for In-Network services

PREMERA
BLUE CROSS

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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, 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, 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.

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 ኣማርኛ 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, ໂດຍບໍ່ເສັຽຄ່າ, 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 (TTY: 711) 800-722-1471 تماس بگیرید.