School Employees Benefits Board (SEBB) Program

Premera Blue Cross HMO

4018486

PREMERA HMO

An Independent Licensee of the Blue Cross Blue Shield Association

Premera Blue Cross HMO is an Independent Licensee of the Blue Cross Blue Shield Association. The benefits, limitations, exclusions and other coverage provisions in this booklet are subject to the terms of our contract with the Group. This booklet is a part of that contract, which is on file in the Group's office and at Premera Blue Cross HMO. This booklet replaces any other benefit booklet you may have received. The Group has delegated authority to Premera Blue Cross HMO to use its expertise and judgment as part of the routine operation of the plan to reasonably apply the terms of the contract for making decisions as they apply to specific eligibility, benefits and claims situations. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal, have independent review of our judgment and decisions, or bring a civil lawsuit challenging to any eligibility or claims determinations under the contract, including our exercise of our judgment and expertise.

The Blue Cross and Blue Shield Association licenses Premera Blue Cross HMO to offer certain products and services under the BLUE CROSS® brand name. Premera Blue Cross HMO is an independent organization governed by its own Board of Directors, and responsible for its own obligations. A copy of Premera Blue Cross HMO's most recent audited financial statement is available on request to Premera Blue Cross HMO.

Medical and payment policies we use in administration of this plan are available at premera.com.

Translation Services
If you need an interpreter to help with verbal translation services, please call us. Customer service will be able to guide you through the service. The phone number is available in ***Contact Information***.

If any provision of this Plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.

Group Name:	Washington State Healthcare Authority For The School Employees Benefits Board Program
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Group Number:	4018486
Plan:	Core Plus
Certificate Form Number:	40184860127HMO

INTRODUCTION

Welcome

Thank you for choosing Premera Blue Cross HMO (PBC HMO) for your healthcare coverage. We're looking forward to taking great care of you.

This is your health plan. It tells you what services we cover, your costs, and how to contact us. We know that health care can be complicated, and we want to help.

What your health plan can help you do

Know your plan

- What do healthcare terms mean?
- Show me real examples of what I'll pay

Find care

- How do I find doctors, facilities, and specialists near me?
- What's available 24/7?

Get care

- How does my plan work?
- What is covered?
- How do I keep my costs low?

Be well

- Preventive care is **free** in-network

Contact Information

Where To Send Claims

MAIL YOUR CLAIMS TO

Premera Blue Cross HMO
P.O. Box 91059
Seattle, WA 98111-9159

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
ATTN: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Administrator At

1-800-391-9701
www.express-scripts.com

Customer Service

Mailing Address
Premera Blue Cross HMO
PO Box 91059
Seattle, WA 98111-9159

Physical Address
7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Phone Numbers
Local and toll-free number:
1-800-807-7310

Local and toll-free TRS number:
711

Care Management

Prior Authorization
Premera Blue Cross HMO
PO Box 91059
Seattle, WA 98111-9159

Local and toll-free number:
1-800-807-7310
Fax 1-800-843-1114

Complaints and Appeals

Premera Blue Cross HMO
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111-9202
Fax: (425) 918-5592

BlueCard

1-800-810-BLUE(2583)

Website

Visit our website **www.premera.com/sebb** for information and secure online access to claims information

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Quick Care Guide

Here are the most common healthcare terms and how they affect what you pay for covered services. There are also examples to show how these terms fit together.

To learn more about amounts you are responsible for, visit ***Covered Services***.

Allowed Amount	The maximum amount PBC HMO pays for a covered service.
Benefit Dollar Maximum	The most that PBC HMO pays for certain benefits within a year. After the limit is met, you pay 100% of costs out of pocket. Amounts that apply to your deductible don't count toward your dollar maximums.
Coinsurance	It's a percentage of the allowed amount that you pay for the service. You start paying coinsurance after you've met your deductible.
Copay or **Copayment**	A fixed amount you pay for each healthcare visit or service. If the amount billed is less than the copay, you only pay the amount billed. Only one office visit copay per provider per day will apply. If the copay amounts are different, the highest will apply. The deductible does not apply to most services that require a copay. Copays apply to the out-of-pocket maximum.
Cost shares	Your share of the allowed amount for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. If you go out-of-network for care, the provider can charge additional amounts, except as prohibited by federal or state law.
Deductible	The amount you pay each year before PBC HMO starts to pay for covered services. The deductible includes an *Individual* and a *Family Deductible*. If you and one or more of your dependents are enrolled in this plan, the family deductible will apply. If any one member satisfies the individual deductible amount, this plan will begin paying for that member's covered services; this type of deductible is called "embedded". When other members satisfy the family deductible, we will consider the family deductible to have been met. Then, this plan will begin paying for all family members' covered services. Deductibles are subject to the following: • Amounts credited toward the deductible will not exceed the allowed amount. • Amounts credited toward the deductible do not add to benefits with an annual dollar maximum. • Amounts credited toward the deductible accrue to benefits with visit limits. Amounts that don't accrue toward the deductible are: • Amounts that exceed the allowed amount. • Charges for excluded services. • Copays There is no carry-over provision. Amounts credited to your deductible during the current calendar year will not carry forward to the next calendar year deductible.
In-Network	Specific providers, hospitals, or labs that PBC HMO contracts with to provide healthcare services to members. You typically pay less when using in-network healthcare providers. Your bills will be reimbursed at a higher percentage. In-network providers will not charge you more than the allowed amount.

Out-of-Network	Services from healthcare providers and hospitals that have not contracted with Premera Blue Cross HMO. This could mean the service will not be paid for at all by PBC HMO. You may also be required to submit the claim yourself.
Out-of-Pocket Maximum	The out-of-pocket maximum is the most you pay for covered services in a year before PBC HMO pays 100% of the allowed amount. The out-of-pocket maximum includes an Individual and a Family Out-of-Pocket Maximum. Expenses that do not apply toward the out-of-pocket maximum include, but not limited to: • Charges above the allowed amount. • Services above any benefit maximum limit or durational limit. • Services not covered by this plan. • Services from out-of-network providers, except as prohibited by state or federal law. • Covered services that do not apply to the out-of-pocket maximum as stated in ***Covered Services***.
Prior Authorization	Some services must be authorized in writing before you get them, in order to be eligible for coverage. The conditions, time limits and maximum limits are described in this booklet.
Referral	A written request from your Primary Care Provider (PCP) to receive certain services from a specialist.
Visit, day, or hour limits	Some covered services have a maximum number of visits, days, or hours. After you reach this limit, you pay 100% out-of-pocket, whether or not you've met your deductible.
Year	The consecutive 12-month period that starts on your health plan's effective date. For this plan, it's a calendar year which begins on January 1 and ends on December 31.

Premera Blue Cross HMO Overview

This plan is a Health Maintenance Organization. This means that the plan is designed to cover care from in-network providers. Your plan provides you benefits for covered services from providers you access within the Clearwater HMO network in Washington. Referrals are required from your Primary Care Provider (PCP) to see specialists for most services, except for emergency services. A prior authorization may be required in addition to a referral. See ***How Providers Affect Your Costs*** for more information.

If a referral is not provided and you choose to receive services from providers or facilities except as specifically indicated in ***Covered Services***, those services will not be covered under this plan. You will be responsible for 100% of the cost for these services and any amounts you pay will not apply to your out-of-pocket maximum, except services required by federal or state law. See ***When Do I Need A Referral To See A Specialist?*** for more information.

A list of HMO network providers including PCPs and specialists is available by contacting customer service or accessing the PBC HMO website at www.premera.com/sebb, and looking up providers using the Clearwater HMO network.

Copay

	In-Network Providers	Out-of-Network Providers
Primary Care Provider copay	$10 copay, deductible waived	Not covered
Specialist copay	$40 copay, deductible waived	Not covered
Emergency room copay	$175 copay, then deductible, 20% coinsurance	$175 copay, then in-network deductible, 20% coinsurance

Coinsurance

	In-Network Providers	Out-of-Network Providers
	20%	Not covered

*See ***In-Network Benefits for Out-of-Network Providers*** for out-of-network services that will always be covered at the in-network level of benefits.

Deductible

	In-Network Providers	Out-of-Network Providers
Individual deductible	$750	Not covered

Family deductible (embedded)	$1,500	Not covered

Out-of-Pocket-Maximum

	In-Network Providers	Out-of-Network Providers
Individual out-of-pocket maximum	$3,500	Not covered
Family out-of-pocket maximum	$7,000	Not covered

***Example**: In-Network Office Visit*

An in-network office visit costs $120, the allowed amount for the service is $100, and your coinsurance is 20% of the $100, or $20. If you've met your deductible, PBC HMO pays 80% of the $100, or $80. You pay the remaining $20.

Office visit charges	**Allowed amount**	**Your coinsurance**	**PBC HMO pays**	**Your total responsibility**
$120	$100	$20 (20% of the allowed amount)	$80 (80% of the allowed amount)	**$20**

Important Plan Information

This plan makes available to you a sufficient number and types of providers to give you access to all covered services in compliance with applicable Washington state regulations governing access to providers. Our provider network includes hospitals, physicians, and a variety of other types of providers.

Getting Care

No ID card yet? No problem. As long as your plan date is effective, you can get care:

- The provider's office can often look up your insurance and see that you're eligible.
- Download the Premera mobile app to get a digital ID card.
  iPhone and Android users can get the app from the Apple or Google Play App Store
- Call PBC HMO customer service for your ID number.

Discover your care choices

You can see or call	When you need	What to do
In-network Primary care and Specialty care providers	Routine, acute, chronic, and specialty care	Select in-network providers. A referral is required for certain specialists. See ***When Do I Need A Referral To See A Specialist?*** Log in to premera.com and click "Find Care." You can search by name, type, or location.
Virtual care	A visit with a provider, counselor, or psychiatrist without going to an office. Have your appointment by computer, tablet, or mobile device wherever you are.	Set up your account at premera.com/sebb, then connect any day, any time, including weekends and holidays. Call customer service for assistance**.**
Urgent Care/Walk-in clinic	Same-day care for medical issues that need urgent attention but are not life threatening. Examples include, rashes, flu, minor burns or cuts, x-rays, and lab tests.	Sign in to **premera.com/sebb** and click "Find Care." Choose or "Urgent Care & Other Facilities" to search for locations closest to you.
Emergency services	Life-threatening emergency services	**Call 911** or go to an emergency room
24-Hour NurseLine	Advice from a registered nurse for illnesses like fevers, the flu, and minor injuries.	Call **800-841-8343** (open 24 hours a day, seven days a week).

Allowed Amount

This plan provides benefits based on the allowed amount for covered services. We determine the amount allowed for any given service or supply using pricing methodologies permitted under the plan and applicable federal or state law. The allowed amount is described below. Different rules apply for certain services as described below.

In-Network

The allowed amount is the fee that we have negotiated with providers who have signed contracts with us and are in your provider network.

Out-of-Network

For non-contracted providers and non-emergent care, the allowed amount for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is determined using the least amount of the pricing methodologies below:

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us.
- The provider's billed charges.
- The following fee schedule determined by the Centers for Medicare and Medicaid Services:
  - 100% of Medicare for drugs covered under the medical benefit
  - 80% of Medicare for home medical equipment, chiropractic adjustments, or outpatient rehabilitation therapy
  - 125% of Medicare for all other services
- At certain out-of-network hospitals in Washington state, when you receive nonemergency inpatient or outpatient facility services you pay the out-of-network cost-sharing amount and cannot be balance billed. Contact Premera customer service if you have any questions about the status of a hospital in Washington state.

If applicable federal or state law requires a different allowed amount than described above, this plan will comply with that law.

Generally, non-emergent care services provided by out-of-network providers is not covered. However, you or your in-network provider may ask for a prior authorization to cover the out-of-network provider at the in-network benefit level if the services are medically necessary and only available from an out-of-network provider. You or your in-network provider must ask for prior authorization before you receive the services. See ***Prior Authorization*** for details.

See ***Out-of-Area Care*** for more detail about providers outside Washington who have agreements with other Blue Cross Blue Shield Licensees.

Non-Emergency Services Protected From Balance Billing

For these services, the allowed amount is calculated consistent with the requirements of federal or Washington state law.

Emergency Services

The allowed amount for out-of-network providers will be calculated consistent with the requirements of federal or Washington state law.

You do not have to pay amounts over the allowed amount for emergency services delivered by out-of-network providers or facilities.

If you have questions about this information, please call us at the number listed on your PBC HMO ID card.

Ground or Air Ambulance

The allowed amount for out-of-network ground or air ambulance providers will be calculated consistent with the requirements of federal or Washington state law.

How Providers Affect Your Costs

MEDICAL SERVICES

This plan is a Health Maintenance Organization (HMO). This means that the plan provides you benefits for covered services from providers in the Clearwater HMO network. You have access to one of the many providers included in this network.

- Hospitals, physicians and other providers in this provider network are called "in-network providers."
- This plan makes available to you a sufficient number and types of providers to give you access to all covered services in compliance with applicable Washington state regulations governing access to providers.
- A list of in-network providers is available in our Clearwater HMO provider directory. These providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you.
- If choose to receive services from out-of-network providers or facilities except as specifically indicated in ***Covered Services***, those services will not be covered under this plan. You will be responsible for 100% of the cost for these services and any amounts you pay will not apply to your out-of-pocket maximum, except services required by federal or state law.

Primary Care Providers

This plan auto-assigns you a primary care provider (PCP) at the time you enroll in the plan. Your PCP must be in the network and be a specific provider type.

- This provider will be your PCP unless you decide to change to another. You can change your PCP at any time by calling PBC HMO customer service or signing into your member portal.
- A list of in-network providers can be found in our Clearwater HMO provider directory on premera.com/sebb.
- For more details and a list of the specific provider types, see ***Important Plan Information***.

HOW TO SELECT A PCP PROVIDER

The provider directory shows which providers you can select as your PCP. The Clearwater HMO provider network directory is available any time on our website at premera.com/sebb. You may also request a copy of this directory by calling customer service at the number located in ***Contact Information*** or on your PBC HMO ID card. We update this directory regularly, but it is subject to change. We suggest that you call us for current information and to verify that your provider, their office location, or provider group is included in the Clearwater HMO network before you receive services.

- You can change your PCP at any time by calling PBC HMO customer service or signing into your member portal.
- If you are having difficulty choosing an available PCP, contact us and we will help you select a PCP or visit premera.com/sebb. You'll find resources to help you choose a PCP who's a good fit for you.
- You may select one PCP for an entire family or a different PCP can be selected for each member on the plan.

IMPORTANT NOTE: Services received from out-of-network providers are not covered under this plan, except services required by federal or state law. See ***In-Network Benefits for Out-of-Network Providers***.

Primary Care Office Visits

Primary Care Office Visits	You pay the PCP cost share for primary care office visits.
Primary Care Providers (PCP)	• Family practice physician • General practice provider • Geriatric practice provider • Gynecologist • Internist • Naturopath • Nurse practitioner • Obstetrician • Pediatrician • Physician Assistant You do not need prior authorization from PBC HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact customer service.
Related Information	• All other covered services, often time referred to as professional services, provided by your selected PCP during the primary care office visit are subject to your deductible and applicable coinsurance. • Example: If you select a PCP and see that PCP for a cut that needs stitches, you will pay the PCP $10 copay for the office visit and will also pay your plan's deductible and/or coinsurance for the stitching procedure.

Specialty Care Provider Services

Specialty care provider services include consultations, evaluations, and treatment by physician specialists. Services provided by certain in-network specialists require a referral from your PCP. You can determine if you need a referral to a specialist by accessing PBC HMO's member portal and your PCP can also access this information through the provider portal.

WHEN DO I NEED A REFERRAL TO SEE A SPECIALIST?

Specialist Office Visits	You pay the specialist cost share for office visits with a specialist.
All services provided by a specialist require a referral, except for the following (Specialists must be in-network)	The following is a list of services provided by a specialist that **do not** require a referral from a PCP. Any service provided by a specialist that is not listed below requires a referral. Please contact customer service, your PCP, or use your member portal for more information about referrals. • Acupuncture • Ancillary services (x-ray, lab, pathology)

	• Anesthesia • Behavioral health • Blood bank services • Chiropractic care • Emergency services • Eye exam • Family planning services • Ground and air ambulance (emergent/urgent care) • Hearing hardware • Home medical equipment (HME) (some supplies require prior authorization) • Inpatient Hospital Ancillary Professional Fees • Naturopathic services (non-PCP) • Newborn care (up to 31 days) • Obstetric care • Outpatient physical, occupational, speech, and massage therapy (benefit limits apply) • Preventive services • Spinal manipulations • Sterilization • Urgent care
Second Opinions	• Second opinions from an in-network provider for medical diagnosis or treatment • A referral from your PCP is required • A referral for a second opinion does not apply to any other services provided by this provider.
Related Information	• All other covered services provided by your PCP during the primary care office visit are subject to standard cost shares. • Example: If you select a PCP and see that PCP for a cut that needs stitches, you will pay the PCP $10 copay for the office visit and will pay your plan's deductible (if not yet met) and coinsurance for the stitching procedure.

HOW DO I GET A REFERRAL?

Your PCP must provide a referral before you can receive care from specialists. Some services provided by in-network specialists do not require referrals as listed in ***When Do I Need A Referral To See A Specialist?*** For more information about referrals, access your member portal. Your PCP can also access this information through the provider portal.

If a referral is not provided and you choose to receive services from providers or facilities except as specifically indicated in ***Covered Services***, those services will not be covered under this plan. You will be responsible for 100% of the cost for these services and any amounts you pay will not apply to your out-of-pocket maximum, except services required by federal or state law. See ***When Do I Need A Referral To See A Specialist?*** for more information.

In-Network Providers	• Networks of hospitals, physicians and other providers that are part of our Clearwater HMO network in Washington. • These providers provide medical services at a negotiated fee. This fee is the allowed amount for in-network providers.

	• When you receive covered services from an in-network provider your medical bills will be reimbursed at the in-network provider benefit level. • In-network providers will not charge more than the allowed amount.
Out-of-Network Providers	• Services provided by providers not in the Clearwater HMO network are not covered unless indicated below.
In-Network Benefits for Out-of-Network Providers	For covered services provided by out-of-network or non-contracted providers, the allowed amount may be determined using negotiated rates, statutory requirements, or other pricing methodologies permitted under the plan. The following covered services and supplies provided by out-of-network or non-contracted providers are covered at the in-network level of benefits as described below • Emergency services for a medical emergency and urgent care services. See ***Definitions*** for definitions of these terms. This plan provides worldwide coverage for emergency services. • Prior authorization and without regard as to whether the health care provider furnishing the services is a network provider. • Emergency services furnished by an out-of-network provider will be reimbursed in compliance with applicable laws. • Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers. • Facility and hospital-based provider services received from a hospital that has a provider contract with Premera Blue Cross HMO. • See also ***Balance Billing Protections***. If a covered service is not available from an in-network provider, you may receive benefits for services provided by an out-of-network or non-contracted provider. However, you or your in-network provider must request this **before** you get the care. See ***Prior Authorization*** for details.

Contracted Health Care Benefit Managers

The list of PBC HMO's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at https://www.premera.com/visitor/partners-vendors and changes to these contracts or services are reflected on the website within 30 business days.

Balance Billing Protections

Out-of-network providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, Washington state and federal law protects you from balance billing for:

Emergency Services from an out-of-network hospital or facility or from an out-of-network provider that works at the hospital or facility.

Emergency services includes certain post-stabilization services you may get after you are in stable condition. These include covered services provided as part of outpatient observation or during an inpatient or outpatient stay related to the emergency visit, regardless of which department of the hospital you are in.

Non-emergency services from **an out-of-network provider** at an **in-network** hospital or outpatient surgery center. If a non-emergency service is not covered under the in-network benefits and terms of coverage under your health plan, then the federal and state law regarding balance billing do not apply for these services.

Ground Ambulance services from an out-of-network ground ambulance service organization for covered ground ambulance services.

Air Ambulance
Your cost-sharing for out-of-network air ambulance services shall be no more than if the services were provided by an in-network provider. The cost sharing amount shall be counted towards the in-network deductible and the in-network out of pocket maximum amount. Cost-sharing shall be based upon the lesser of the qualifying payment amount (as defined under federal law) or the billed amount.

For more information, refer to www.insurance.wa.gov/sites/default/files/2025-02/consumer-notice-suprise-billing.pdf.

For the above services, you will pay no more than the plan's in-network cost-shares. PBC HMO will work with the out-of-network provider to resolve any issues about the amount paid. Premera HMO will also send the plan's payments to the provider directly.

Note: Amounts you pay over the allowed amount don't count toward any applicable calendar year deductible, coinsurance, or out-of-pocket maximum.

Care Management

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important, as explained below.

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call customer service at 1-800-807-7310 to verify that you meet the required criteria for claims payment and to help us identify if you might benefit from case management.

PRIOR AUTHORIZATION

You must get PBCHMO's approval for some services before the service is performed, or you may not have coverage for the service. This process is called prior authorization. A referral to an in-network provider or facility may be required in addition to obtaining prior authorization for services.

There are two different types of prior authorization required:

Prior Authorization Type	What it means
Benefit Coverage	You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays. This is so that PBC HMO can confirm that these services are medically necessary and covered by the plan.
Cover Out-of-Network Providers at In-Network Cost Shares	You or your in-network provider must get prior authorization in order for an out-of-network provider to be covered at the plan's in-network benefit level, except for urgent and emergency services. See ***Exceptions To Prior Authorization For Out-of-Network Providers*** below for more information.

How Prior Authorization Works

We will make a decision on a request for services that require prior authorization in writing within 5 calendar days of receipt of all information necessary to make the decision. The response will let you know

whether the services are authorized or not, including the reasons why. If you disagree with the decision, you can ask for an appeal. See ***Complaints and Appeals.***

If your life or health would be in serious jeopardy if you did not receive treatment right away, you may ask for an expedited review. We will respond in writing as soon as possible, but no more than 48 hours after we get all the information we need to make a decision.

Our prior authorization will be valid for at least 90 calendar days. This 90-day period depends on your continued coverage under the plan. If you do not receive the services within that time, you will have to ask us for another prior authorization.

1. Prior Authorization for Benefit Coverage

Benefit	Description
Medical Services, Supplies or Equipment	The plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility. Please contact your in-network provider or PBC HMO customer service before you receive a service to find out if your service requires prior authorization. • **In-network providers or facilities** are required to request prior authorization for the service. • **Out-of-network providers and facilities** will not request prior authorization for the service. You have to ask PBC HMO to prior authorize the service. You also have to get prior authorization for coverage of services from an out-of-network provider. See ***Prior Authorization for Out-of-Network Provider Coverage*** below. **If you do not ask for prior authorization, and the plan covers the service, you will have to pay a penalty.** The penalty amount is 50% of the allowed amount. However, you will not have to pay more than a $1,500 penalty per occurrence. You also have to pay your cost-share. For a drug covered under the medical benefit, coverage is provided for approved therapies based on drug availability. When a generic or biosimilar (“generic biological product”) of an approved drug is available, generic drug substitution applies. The generic or biosimilar drug provides the same therapeutic benefit for the approved condition. This can happen at any time throughout the year; if this does occur, we’ll notify you in writing 90 days before the change happens.
Prescription Drugs	The plan has a specific list of prescription drugs that must have prior authorization before you get them at a pharmacy. The list is on our website at premera.com/sebb. Your provider can ask for a prior authorization by faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website. • If your provider does not get prior authorization, when you go to the pharmacy to get your prescription, the pharmacy will tell you that you need it. • You or your pharmacy should inform your provider of the need for prior authorization. • Your provider can fax us an accurately completed prior authorization form for review.
	Emergency Fill

	The plan may cover a small supply of the drug to allow more time for the prior authorization. The cost-shares shown in ***Covered Services*** will apply. In-Network pharmacies will find out if an emergency fill is covered for your drug. The authorized amount of the emergency fill will be no more than the prescribed amount, up to a seven-day supply or the minimum packaging size available at the time the emergency fill is dispensed. See the process for emergency fills on our website at premera.com/sebb. If an emergency fill is not allowed for your drug, you can still buy the drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See ***How Do I File a Claim?*** for details.
	Limitations Sometimes, benefits for some prescription drugs may be limited to one or more of the following: • A set number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment. • Certain drugs for a specific diagnosis • Certain drugs from certain pharmacies, or you may need to get a prescription drug from an appropriate medical specialist or a specific provider • Step therapy, meaning you must try a generic drug or a specified brand name drug(s) first • Drug synchronization, meaning the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. Cost-shares are adjusted if the fill is less than the standard refill amount in compliance with Washington state law. These limits are based on medical standards, the drug maker's advice, and your specific case. They are also based on FDA guidelines and medical articles and papers.
Exceptions to Prior Authorization	The following services do not require prior authorization for benefit coverage: • The first six visits provided by an in-network provider for rehabilitation and habilitation therapy, spinal manipulative treatment or acupuncture. • Emergency services, urgent care, and emergency hospital admissions, including emergency drug or alcohol detox in a hospital. • Services provided under involuntary commitment statutes are covered. • Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth. Emergency admissions and childbirth hospital admissions do not require prior authorization, but you must notify us as soon as reasonably possible.

2. Prior Authorization for Out-of-Network Provider Coverage

Out-of-Network Provider Services	Generally, non-emergent care services provided by out-of-network providers are not covered. However, you or your in-network provider may ask for a prior authorization to cover the out-of-network provider at the in-network benefit level if the services are medically necessary and only available from an out-of-network provider. You or your in-network provider must ask for prior authorization before you receive the services. You will need to reach out to your in-network provider to have them submit the appropriate forms. You may also initiate the process yourself by calling the toll-free customer support number on the back of your ID card. When we receive your request, we will confirm there are no in-network providers who can provide the requested services. If there is an in-network provider available, your prior authorization request for coverage of services from an out-of-network provider will not be authorized. **Note: It is your responsibility to get prior authorization for any services that require it when you see a provider that is out-of-network. If you do not ask for prior authorization, and the plan covers the service, you will have to pay a penalty.** The penalty amount is 50% of the allowed amount. However, you will not have to pay more than $1,500 penalty per occurrence. You also have to pay your cost-share. The prior authorization request for an out-of-network provider must include the following: • A statement explaining how the provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from an in-network provider, and • Medical records needed to support the request. If the out-of-network services are authorized, the plan will cover the service. **However, in addition to the cost shares, an out-of-network provider can bill you for any amounts over the allowed amount if the provider does not have a contract with us,** except for emergency services, covered air ambulance services, or as prohibited by law**. Amounts over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.**
Exceptions to Prior Authorization for Out-of-Network Providers	Out-of-network providers can be covered without prior authorization for emergency services, urgent care, and hospital admissions for a medical emergency. This includes hospital admissions for emergency drug or alcohol detox or for childbirth. If you are admitted to an out-of-network hospital due to an emergency condition, those services are always covered. We will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital. Emergency services furnished by an out-of-network provider will be reimbursed in compliance with applicable laws. If you choose to stay in the out-of-network hospital after you are medically stable and can safely transfer to an in-network hospital, you

	may be subject to additional charges which may not be covered by your plan, including charges above the allowed amount.

CLINICAL REVIEW

Clinical review is a summary of medical and payment policies. These are used to make sure that you get appropriate and cost-effective care. Our policies include:

- Accepted clinical practice guidelines
- Industry standards accepted by organizations like the American Medical Association (AMA)
- Other professional societies
- Center for Medicare and Medicaid Services (CMS)

You can find our medical policies at www.premera.com/sebb.

PERSONAL HEALTH SUPPORT PROGRAMS

Premera Blue Cross HMO personal health support programs are designed to help make sure your health care and treatment improve your health. You will receive individualized and integrated support based on your specific needs. These services could include working with you and your provider to ensure appropriate and cost-effective medical care, to consider effective alternatives to hospitalization, or to support both of you in managing chronic conditions.

Your participation in a treatment plan through our personal health support programs is voluntary. To learn more about the programs, contact customer service at the number listed on your PBC HMO ID card.

CONTINUITY OF CARE

How Continuity of Care Works: You may qualify for Continuity of Care (COC) under certain circumstances when a provider leaves your health plan's network or your employer transitions to a new carrier. This will depend on your medical condition at the time the change occurs. COC is a process that provides you with short-term, temporary coverage at in-network levels for care received by an out-of-network provider.

COC applies in these situations:

- The contract with your provider ends
- The benefits covered for your provider change in a way that results in a loss of coverage
- The contract between your company and us ends and that results in a loss of coverage of your provider

How you qualify for Continuity of Care: If a professional provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination. During this time, PBC HMO will consider the professional provider to still have an agreement only while this policy remains in effect and

- For the period that is the longest of the following:
    - The end of the current policy year
    - Until the end of the next open enrollment period, as required under state law
    - Up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment
    - Through completion of postpartum care, if the member is pregnant on the date of termination; or
- Until the end of the medically necessary treatment for the medical condition if the member has a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year.

We will notify you at least 30 days prior to your provider's termination date. When a termination for cause provides us less than 30 days' notice, we will make a good faith effort to assure that a written notice is provided to you immediately.

You can request continuity of care by contacting customer service. See ***Contact Information***.

If you are approved for continuity of care, you will get continuing care from the terminating provider until the earlier of the following:

- The 90th day after we notified you that your Primary Care Provider (PCP)'s contract ended
- The day after you complete the active course of treatment entitling you to continuity of care

If you are pregnant and eligible for continuity of care, you can continue with your provider throughout your pregnancy, plus 8 weeks postpartum care.

Continuity of care does not apply if your provider:

- No longer holds an active license
- Relocates out of the service area
- Goes on leave of absence
- Is unable to provide continuity of care because of other reasons
- Does not meet standards of quality of care

When continuity of care ends, non-emergent covered care from the provider is no longer covered. If we deny your request for continuity of care, you may appeal the denial. See ***Complaints and Appeals***.

LEVELS OF CARE

Healthcare is delivered in many settings with distinct levels of care. Each level of care involves a different intensity of service to treat your medical and behavioral health symptoms. Premera covers the least intensive level of care that is medically necessary to treat your symptoms. Care is often provided in a continuum beginning with acute care and transitioning to outpatient care as symptoms or condition improve. Please see Premera medical policies for Medical Necessity criteria for each type of care.

Acute Inpatient Level of Care

- Medical, surgical or behavioral health hospitals (see ***Definitions*** for Hospital or Inpatient)

Acute facilities provide treatment for severe episodes of Illness, Injury, or behavioral health symptoms, and for recovery from surgery. You are monitored for medical, surgical and psychiatric symptoms, with 24-hour availability of appropriate medical and psychiatric practitioners, and 24/7 onsite nursing services. Care may begin in the emergency room or an outpatient medical, surgical, or behavioral health setting with transition to an acute inpatient level of care to address your needs. Specialty-appropriate physicians, nurse practitioners, or physician assistants perform physical examinations or psychiatric evaluations within one day of hospital admission. Hospitals provide daily physical examination or psychiatric evaluation, daily nursing observation, and daily treatment during the stay. A plan for treatment and transition to lower levels of care is established shortly after admission. A brief hospital stay while on Observation is considered to be Outpatient care.

Acute care facilities are licensed by the applicable state health department as a hospital or as a behavioral health evaluation and treatment facility.

Intermediate Level Facilities

- Long-term Acute Care Hospitals (LTAC or LTACH)
- Inpatient Rehabilitation Hospitals or Units
- Skilled Nursing Facilities (see ***Definitions*** for Skilled Nursing Facility and Skilled Nursing Care)
- Residential Treatment Programs in residential treatment facilities or wilderness settings

Intermediate care facilities are a bridge between acute and outpatient care settings. They serve those who do not require the intensity of service that acute hospitals provide, but are not yet ready to step-down to outpatient care. Their purpose is to improve function and stabilize you for transition to outpatient

services. Intermediate level facilities provide care for patients' medical needs as well as daily living support. Patients typically reside in the facility for the duration of their treatment.

Intermediate level care may be provided in a free-standing facility or in a segregated location within another facility. Wilderness programs providing behavioral health care in an outdoor setting and with the structure and intensity of a residential treatment program are also intermediate level care. Inpatient Hospice and facilities providing Custodial Care are not intermediate level facilities.

Intermediate care facilities are licensed by the applicable state health department as a healthcare or behavioral health facility. A program operating under another type of state licensure, such as a child-care license, is not an intermediate facility. Intermediate care facilities have the following characteristics:

- Onsite nursing at all times (or, for behavioral health programs, on-call nursing and onsite mental health practitioner)
- Admission evaluation or psychiatric assessment by an appropriately licensed provider by at least shortly after admission and at least weekly (every seven days) thereafter
- Daily treatment by appropriate licensed clinical providers
- A plan for treatment established shortly after admission
- Discharge planning for transition to lower levels of care

Please see Premera medical policies for Medical Necessity criteria for each type of care.

Intermediate Level Ambulatory or Outpatient Care

- Partial Hospitalization Programs for Psychiatric or Substance Use Disorder Treatment
- Intensive Outpatient Psychiatric or Substance Use Disorder Treatment Programs
- Home Health Care
- Residential Neurological Rehabilitation or Rehab Without Walls

Intermediate level outpatient programs provide intensive services to those who can function safely in a community-based setting but require a higher level of care than is provided in an outpatient office visit. Intermediate level outpatient programs may be provided by inpatient or intermediate level facilities however patients typically reside at their own homes and visit the facilities for treatment only. Some may offer programs where you can pay to reside within the facility while an outpatient level of care is provided when facility is away from your home.

Outpatient Care

- Hospital Observation
- Hospital Emergency Department
- Ambulatory Surgical Center or Outpatient Surgical Center
- Ambulatory or Outpatient Rehabilitation
- Urgent Care
- Office Visits
- Virtual Care

Outpatient care may be provided in hospital, surgical center, clinic, or office settings, or remotely through virtual care. Outpatient services are unstructured and provide maximum freedom.

Covered Services

This section talks about the benefits that are available with this plan and your costs. They are listed in alphabetical order.

Services of these benefits are available when they meet all of these requirements:

- It must be given in connection with the prevention or diagnosis and treatment of a covered illness, disease, or injury.

- The service takes place in a medically necessary setting. This plan covers inpatient care only when you cannot get the services in a less intensive setting.
- Must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan.
- It must be given by a provider who's performing services within the scope of their license or certification.
- It must meet the standards set in our medical and payment policies. The plan uses policies to administer the terms of the plan.
- Some types of services may be limited or excluded under this plan.

Related Benefit Information

- To learn more about terms like medical necessity and provider, see ***Definitions***.
- See ***Exclusions and Limitations*** for a complete description of limitations and exclusions.
- This plan complies with Washington state and federal regulations about diabetes medical treatment coverage. Please see ***Preventive Care***, ***Prescription Drugs***, ***Home Medical Equipment (HME) Orthotics, Prosthetics and Supplies***, and the ***Foot Care*** benefits.

Medical services must meet the standards set in our medical and payment policies. The plan uses policies to administer the terms of the plan. Our policies are available to you and your provider at premera.com/sebb or by calling customer service.

Medical policies define medical necessity for specific procedures, drugs, biologic agents, devices, level of care or services. They also identify medical services that are not covered because they are experimental and investigational. Medical policies may be developed by PBC HMO or licensed from national organizations that create evidence-based utilization standards.

Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS).

Acupuncture

The technique of inserting thin needles through the skin at specific points on body to help control pain and other symptoms. Services must be provided by a certified or licensed acupuncturist.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-Network
Office and clinic visits	24 visits / year	$10 copay, deductible waived	Not covered
Other outpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**Acupuncture that is used to:** • Relieve pain • Provide anesthesia for surgery • Treat a covered illness, injury, or condition

Allergy Testing and Treatment

Skin and blood tests used to diagnose what substances a person is allergic to, and treatment for allergies. Services must be provided by a certified or licensed allergy specialist.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Testing and treatment	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Testing • Allergy shots • Serums
Related benefit information	• If you receive allergy testing in an office setting, you may also be billed for an office visit. See ***Professional Visits and Services***.

Ambulance

Medical transportation, usually for emergencies.

Important things to know:

- Air or sea emergency transport is only covered under certain circumstances. See the ***Benefit Overview*** below for full details.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Ambulance	No limit	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance

Benefit Overview

What services are included?	• Transport to the nearest facility that can treat your condition. • Medical care you get during the trip. • Transport from one medical facility to another, as needed for your condition. • Transport to your home when medically necessary. **These services are only covered when:** • Any other type of transport would put your health or safety at risk. • The service is from a licensed ambulance. • It is for the member who needs transport. **Ground ambulance services** **Air or sea emergency transportation is only covered when all the above requirements for ambulance services are met and:** • Transport takes you to the nearest available facility that can treat your condition. • Geographic restraints prevent use of a ground transport. • Ground emergency transportation would put your health or safety at risk.
What is excluded? (PBC HMO pays 0%)	• Services from an unlicensed ambulance.
Related benefit information	• Ambulance services that are not for an emergency must be medically necessary and need prior authorization. See ***Prior Authorization***.

Additional Information

Ground ambulance services means:

- The rendering of medical treatment and care at the scene of a medical emergency or while transporting a member to an appropriate emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose; and
- Ground ambulance transport between emergency services providers, emergency services providers and medical facilities, and between medical facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose.

Ambulatory Surgical Center

A healthcare facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated mainly for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Important things to know:

- A typical ambulatory surgical center visit results in multiple charges for things like the facility, professional services, and tests used to diagnose your condition. You may receive separate bills for each charge.
- Some outpatient surgeries must have prior authorization before you have them. See ***Prior Authorization*** for details.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Outpatient professional care	No limit	Deductible, then 10% coinsurance	Not covered
Outpatient facility charges	No limit	Deductible, then 10% coinsurance	Not covered

Benefit Overview

What services are included?	• Doctor and nurse services • Operating rooms, procedure, and recovery rooms • Surgical supplies and anesthesia • Surgical services, including injections, when performed on an outpatient basis • Drugs, blood, medical equipment, and oxygen for use in the ambulatory surgical center • Diagnostic colonoscopy and sigmoidoscopy services not covered under ***Preventive Care*** • X-ray, lab, and testing billed by the ambulatory surgical center • Medically necessary detoxification
What is excluded? (PBC HMO pays 0%)	• Inpatient room and board • The use of an anesthesiologist for monitoring and administering general anesthesia for endoscopies, colonoscopies and sigmoidoscopies unless medically necessary when specific medical conditions and risk factors are present

	• Cosmetic surgery
Related benefit information	• You may need to pay charges over the allowed amount if you get care from an out-of-network provider. See ***How Providers Affect Your Costs*** for details. • For preventive colonoscopy benefits, see ***Preventive Care***.

Anticancer Medication and Radiation Therapy

Treatment which uses anti-cancer drugs (chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells.

Important things to know:

- Anticancer medication and radiation must be prescribed by a provider and approved by PBC HMO to be covered. See ***Prior Authorization.***
- If you are prescribed oral anticancer medication, it is covered under ***Prescription Drug***.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Facility charges	No limit	Deductible, then 20% coinsurance	Not covered
Professional services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Outpatient anticancer medication and radiation therapy • Supplies, solutions, and drugs used during an anticancer drug treatment or radiation visit • Tooth extractions to prepare your jaw for radiation therapy
Related benefit information	• See ***Prior Authorization*** for more information on getting prior approval for services. • See ***Prescription Drug*** for information on oral anticancer medication. • See ***Cellular Immunotherapy and Gene Therapy*** for information on these treatments, which is covered for some types of cancer. • Drugs you get from a pharmacy are not covered.

At-Home Care

This section will go over the two main types of at-home care:

- Home health care (which is occasional and short-term)
- Skilled hourly nursing (which is intensive and continual care)

Home health care

Home health care is occasional visits by a medical professional employed by a home health agency that is state-licensed or Medicare-certified. This short-term care is designed to help a patient prevent or recover from an illness, injury, or hospital stay.

Home health care provided by licensed home health, hospice and home care agencies may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is medically necessary and home health care:

- Can be provided at equal or lesser cost;
- Is the most appropriate and cost-effective setting; and
- Is substituted with the consent of the member and upon the recommendation of the member's doctor or licensed provider which will adequately meet the member's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the member. We may require a written treatment plan that has been approved by the member's doctor or licensed provider. Substituted home health care benefits available for hospital care or other inpatient care services are covered as stated in the ***Cost Overview***.

Important things to know:

- Coverage requires that a provider states in writing that care is needed in your home.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Home visits	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Home medical equipment, supplies, and devices billed as part of the home visit. • Prescription drugs given by the home health agency. • Physical, occupational, or speech therapy to help regain function.
Whose services are covered?	**When provided by a home health agency, the following are covered:** • A registered nurse. • A licensed practical nurse. • A licensed physical or occupational therapist. • A certified speech therapist.

	• A certified respiratory therapist. • A home health aide directly supervised by one of the above listed providers. • A licensed social worker.
. **What is excluded? (PBC HMO pays 0%)**	• Over-the-counter drugs, solutions, nutritional supplements. • Non-medical services, like housekeeping. • Services that bring you food or advice about food. • The independent hiring of a nurse by a family or member to provide care without oversight by a home health agency.
Related benefit information	• See ***Home Medical Equipment (HME) Orthotics, Prosthetics and Supplies*** for additional benefit information. • See ***Prescription Drugs*** related to medications. Some services require prior approval. See Prior Authorization for details.

Skilled hourly nursing

Skilled hourly nursing is continuous, daily care for homebound patients with oversight by a home health agency. This longer-term care is designed to help patients with a chronic illness, injury, or disability.

Important things to know:

- This benefit is only covered when it's an alternative to hospitalization.
- Prior authorization is required.
- A written plan of care from your provider is required.

Examples of skilled hourly nursing services include:

- Ventilator dependent or tracheostomy patients.
- Patients who are chronically ill and require extensive care to remain at home.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Skilled hourly nursing	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	Benefits are provided by a registered nurse or licensed practitioner when: • The patient is homebound, • Services are medically necessary, and • Such care is prescribed by a physician.
What is excluded? (PBC HMO pays 0%)	• Non-medical services, such as housekeeping. • Services that bring you food, such as Meals on Wheels, or advice about food. • Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature.
Related benefit information	• See ***Prior Authorization*** to learn about the process used to get this benefit covered.

Blood Products and Services

Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Blood products and services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.
Related benefit information	• See ***Prescription Drugs*** related to medications. • Some services require prior approval. See ***Prior Authorization*** for details.

Cellular Immunotherapy and Gene Therapy

Treatment which uses your body's own immune system or genes to treat disease.

Important things to know:

- **These treatments must meet three criteria in order to be covered:**
  - Be prescribed by a provider
  - Meet PBC HMO's medical policy (see **premera.com/sebb** or call customer service), and
  - Be approved by PBC HMO before they happen (see ***Prior Authorization***)
- What you pay and what is covered is based on the type of service you get. See ***Related Benefit Information*** below for details.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Cellular Immunotherapy and Gene Therapy Services	No limit	Covered as any other service	Not covered

Benefit Overview

What services are included?	• Medically necessary cellular immunotherapy and gene therapy, like CAR-T
Related benefit information	• You may have additional costs for other services such as x-rays and labs. See those covered services for details. • If you travel more than 50 miles for these therapies, keep all receipts. You can be reimbursed for some expenses, up to $7,500 per episode of care. See ***Medical Transportation*.** • See ***Prior Authorization*** for more information on getting prior approval for services. • Facility charges are covered under ***Hospital***. • Professional services are covered under ***Professional Visits and Services***. • See ***Prescription Drugs*** related to medications.

Chiropractic Adjustments

This benefit covers spinal and other adjustments to treat a covered illness, injury, or condition. Adjustments are often performed by chiropractors but may also be provided by other licensed professionals such as osteopathic physicians and physical therapists.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Adjustments	24 visits / year	$10 copay, deductible waived	Not covered

Benefit Overview

What services are included?	• Spinal manipulations and adjustments.
Related benefit information	• Your healthcare provider may give you physical therapy services in addition to adjustments. These services are covered under ***Rehabilitation Therapy*** and ***Neurodevelopmental (Habilitation) Therapy***. • You may receive x-rays during your adjustment visit. These services are covered under ***Diagnostic X-ray, Lab and Imaging***.

Clinical Trials

Qualified clinical trials are scientific studies that test and try to improve treatments. Often, clinical trials are for cancer and other life-threatening conditions.

Important things to know:

- To be covered, the clinical trial must be suitable for your health condition, and you must be enrolled in the trial at the time of treatment. We encourage you or your provider to call PBC HMO customer service before you enroll in a clinical trial.
- What you pay and what is covered is based on the type of service you get. See ***Related Benefit Information*** below for details.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Routine patient care during the trial	No limit	Covered as any other service	Not covered

Benefit Overview

What services are included?	• Qualified clinical trial may include medical services, devices and drugs that are already covered under this plan.
What is excluded? (PBC HMO pays 0%)	• The drug, device, or service being tested by the trial. • Costs for treatment outside of patient care, such as: • Travel, housing, and meal costs related to the trial (Note: these may be covered by the clinical trial itself). • Services provided to you in a clinical trial that are fully paid for by another source. • Services that are not consistent with established standards of care for a certain condition. • Services that are not routine costs normally covered under this plan.
Related benefit information	• You may have additional costs for other services such as x-rays, lab, prescription drugs, and hospital facility charges. See those covered services for details. • You should clarify in advance with the clinical trial team what is paid for directly by the clinical trial • Facility charges are covered under ***Hospital***. • See ***Prescription Drugs***. • Office visits are covered under ***Professional Visits and Services***. • Lab and diagnostic tests that are primarily for patient care are covered under ***Diagnostic X-ray, Lab, and Imaging***.

Additional Information

A qualified clinical trial means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, diagnosis, or treatment of cancer or other life-threatening diseases or conditions, and it is either federally funded or approved, conducted under FDA investigational new drug application, or drug trial exempt from FDA investigational new drug application.

The study must be approved by an institutional review board that complies with federal standards for protecting human research subjects and one or more of the following:

- The US Department of Health and Human Services, National Institutes of Health, or its institutes or centers.
- The United States Food and Drug Administration (FDA).
- The US Departments of Veterans Affairs or Defense.
- An institutional review board in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the National Institutes of Health.
- A qualified research entity that meets the criteria for National Institutes of Health Center Support Grant eligibility.
- A National Institutes of Health (NIH) cooperative group or center that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

Dental Injury and Facility Anesthesia

This section will go over two types of dental care:

- Dental care for medical injuries.
- Anesthesia for routine dental care when medically necessary.

Dental Injuries

This benefit covers exams and treatments of injuries to the gum, tooth, and jaw; and oral surgery when related to an accident/injury and is medically necessary.

Important things to know:

- Treatment of dental injuries are covered within 12 months of the injury. If more time is needed, ask your provider to contact PBC HMO customer service.
- Treatments for an injury can result in multiple charges for things like facility, exams, and tests used to diagnose your condition. You may receive separate bills for each charge. See ***Related Benefit Information*** below for details.
- This benefit covers sound and natural teeth that:
  - Do not have decay.
  - Do not have a large number of restorations, such as crowns or bridge work.
  - Do not have gum disease or any condition that would make them weak.
- Sound natural tooth means a tooth that:
  - Is organic and formed by the natural development of the body (not manufactured).
  - Hasn't been extensively restored.
  - Hasn't become extensively decayed or involved in periodontal disease.
  - Isn't more susceptible to injury than a whole natural tooth.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Exams and treatment	No limit	Covered as any other service	Covered as any other service

Benefit Overview

What services are included?	**Dental Injury** • Exams • Consultations • Treatment of dental injuries to teeth, gum, and jaw • Oral surgery
What is excluded? (PBC HMO pays 0%)	• Routine dental care, such as x-rays and cleanings, are not covered under this benefit. • Injuries from biting or chewing, including injuries from a foreign object in food. • Oral surgery treating any fracture of the mandible (jaw) (This is covered under ***Surgery***.)

Related benefit information	
	• You may have additional costs for other services such as x-rays and lab. See those covered services for details. • Facility charges are covered under ***Hospital.*** • See ***Prescription Drugs.*** • Lab and diagnostic tests are covered under ***Diagnostic X-Ray, Lab, and Imaging.*** • If surgery is needed due to injuries that involve dental or oral conditions, treatments would be covered under ***Surgery***.

Anesthesia for Routine Dental Care

Anesthesia for routine dental care is covered for any one of the following reasons when medically necessary and is only overed when provided by an anesthesia professional at an outpatient surgery center, inpatient facility, or when under inpatient professional care

- The member is under age 19 and failed patient management and was not able to tolerate the dental procedure in the dental office.
- The member has a disability, medical, or mental health condition making it unsafe to have care in a dental office.
- The severity and extent of the dental care prevents care in a dental office.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Anesthesiologist	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient surgery center	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

	Dental Anesthesia
What services are included?	• Hospital or other facility care. • General anesthesia provided by an anesthesia professional other than the dentist or the physician performing the dental care.
What is excluded? (PBC HMO pays 0%)	• Routine dental care, including the professional charges of the dentist or services received in the dental office.

Related benefit information	• Tooth extractions related to radiation treatment are covered under ***Anticancer Medication and Radiation Therapy***. • Services related to TMJ are covered under ***Temporomandibular Joint Disorders Care*** (TMJ).

Diagnostic, X-ray, Lab, and Imaging

Diagnostic x-ray, lab and imaging services are basic and major medical tests that help find or identify diseases.

Cost Overview

Important things to know:

- Some tests or imaging may require PBC HMO's approval to be covered. See ***Prior Authorization***.
- A typical diagnostic test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge.

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Preventive care screening/tests (see specific criteria under *Preventive Care*)	No limit	No charge	Not covered
Basic	No limit	$75 copay, deductible waived	Not covered
Major	No limit	$150 copay, deductible waived	Not covered
Radiology at Premera HMO Centers of Excellence	No limit	Covered as any other service	Not covered

Benefit Overview

What services are included?	• Major diagnostic images and scans:
	  • High technology ultrasound
	  • MRI (Magnetic Resonance Imaging)
	  • MRA (Magnetic Resonance Angiography)
	  • CT scan (Computed Tomography)
	  • PET scan (Positron Emission Tomography)
	  • Nuclear Cardiology
	• Basic diagnostic images and scans
	• Preventive care screening and tests. See ***Preventive Care***.

What is excluded? (PBC HMO pays 0%)	• Treatment of infertility, including but not limited to surgery, fertility drugs, and other medications associated with fertility treatment.

	• Non-diagnostic testing or screening required for employment, schooling, or public health reasons that are not for the purpose of treatment.
Related benefit information	• You may have additional costs for other services such as hospital facility charges. See those covered services for details. • Facility charges are covered under Hospital. • See ***Emergency Services*** for diagnostic tests in an emergency room. • See ***Maternity Care*** for diagnostic tests on a fetus. • See ***Preventive Care*** for routine screening of health status. • Genetic testing may be covered in some cases. Call customer service before seeking testing since it may require ***Prior Authorization***. When prescribed by an in-network provider, prior authorization is not required for biomarker testing for members with stage 3 or 4 cancer, or for members with recurrent, relapsed, refractory, or metastatic cancer.

Dialysis

Dialysis is a treatment that performs the functions of healthy kidneys. It is needed when your own kidneys can't take care of your body's needs.

Important things to know:

- The cost of dialysis can be substantial. We recommend calling customer service to find in-network providers.
- After completing an initial dialysis treatment period, which is the period prior to the first day of the fourth month of your dialysis treatment, your cost share amounts will change.
- When covered dialysis services are provided by an out-of-network provider in a county in Washington state where no in-network providers are available, the in-network cost shares will apply.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Initial Dialysis Treatment Period (period prior to the first day of the fourth month of your dialysis treatment)	No limit	Deductible, then 20% coinsurance	Not covered
After the Initial Dialysis Treatment Period	No limit	No charge	Not covered

Benefit Overview

What services are included?	• Dialysis treatments in an outpatient facility or hospital setting or in your home.
Related benefit information	• See ***Prescription Drugs*** for medications for use after you leave the dialysis facility. • See ***How Providers Affect Your Costs*** for information about when out-of-network providers are covered. • See ***Allowed Amount*** in ***Important Plan Information.***

Emergency Services

An emergency medical condition is an illness, injury, symptom, or condition so serious that you need care right away to avoid harm. This plan provides worldwide coverage for emergency services.

Important things to know about emergency services:

- A typical emergency room visit results in multiple charges for things like the facility, professional services, and tests used to diagnose your condition. You may receive separate bills for each charge and from different providers.
- Once you're stabilized, you will incur out-of-network charges if you choose to stay in an out-of-network facility.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Facility charges **(ER copay waived if admitted)**	No limit	$175 copay, then deductible, 20% coinsurance	$175 copay, then in-network deductible, 20% coinsurance
Professional services	No limit	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance

Benefit Overview

What services are included?	• Emergency room and provider services. • Equipment, supplies, and drugs used in the emergency room. • Diagnostic tests performed with other emergency services (some may have additional costs, like x-rays or labs). • Medically necessary detoxification. • Services and exams to stabilize an emergency medical condition, including mental health or substance use disorder. • Emergency services for complications from non-covered services.
What is excluded? (PBC HMO pays 0%)	• If you use ambulance services that are not for an emergency.
Related benefit information	• See ***Ambulance*** for additional benefit information. • See ***Prescription Drug*** for benefits related to medications for use after you leave the emergency room.

Foot Care

This section will cover medically necessary foot care services that need care from a provider. Routine foot care is covered for some medical conditions, as indicated below.

Examples of medical conditions include:

- Diabetes.
- Lymphedema.
- Athlete's foot.
- Bunions.
- Fungus of the foot or toenails.
- Ingrown toenails.
- Warts.
- Any other medical diagnosis or service in which foot care is deemed medically necessary.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
In an office or clinic	No limit	See Professional Visits and Services	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Medically necessary foot care performed by a licensed provider. • A medical provider can cut or remove corns, calluses, and nails related to a certain medical condition.
What is excluded? (PBC HMO pays 0%)	• Routine foot care, such as trimming of nails and removing calluses, that can be done by the member or a caregiver and that do not require skills from a qualified provider. • Non-medically necessary foot care.
Related Benefit Information	• When prescribed by a provider, corrective or therapeutic shoes and orthotics are covered under ***Home Medical Equipment (HME) Orthotics, Prosthetics and Supplies.***

Gender Affirming Care

Medically necessary services and care related to gender-affirming medical care or surgery. Gender transition or affirmation is the process of changing the gender characteristics a person was born with to the gender characteristics with which a person identifies.

Important things to know:

- Benefits are provided for gender affirming surgical services which meet the requirements of the PBC HMO's medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from customer service, or at premera.com/sebb.
- For more information, visit www.premera.com/visitor/care-essentials/lgbt-health.
- If you can't find an in-network provider, or need information about what services are covered under your plan, call customer service.
- Gender-affirming surgery must be approved by PBC HMO ahead of time. See ***Prior Authorization*** for details.

Gender affirming surgery results in multiple charges for things like the facility and professional services. You may receive separate bills for each charge.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	See Professional Visits and Services	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Gender affirming surgeries. • For a full list of services, see our medical policy by calling customer service or visit **www.premera.com/sebb**.
What is excluded? (PBC HMO pays 0%)	• Procedures that are not medically necessary for gender affirming surgery. • Surgery to change the appearance of prior gender change procedures, except when medically necessary.
Related benefit information	• For mental health services, see ***Mental Health Care***. • Hormone treatments are covered under the ***Prescription Drug*** benefit. • For covered surgery benefits not part of gender affirming care, see ***Surgery***.

Hearing Care

Hearing care benefits include hearing exams and hearing hardware.

Hearing Exam

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Hearing exam	One per calendar year	No charge	Not covered

Benefit Overview

What services are included?	• Examinations of the inner and exterior of the ear. • Observation and evaluation of hearing, such as whispered voice and tuning fork. • Case history and recommendations. • Hearing testing services including the use of calibrated equipment.
What is excluded? (PBC HMO pays 0%)	• Hearing hardware. • Fitting examinations for hearing hardware. See ***Hearing Hardware***

Hearing Hardware

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Hearing hardware	One device per ear with hearing loss every 3 years	No charge	No charge

Benefit Overview

What services are included?	• To receive your hearing hardware benefit, you must:
	  ○ Be examined by a licensed provider before obtaining hearing aids.
	  ○ Purchase a hearing aid device.
	• Hearing aids (monaural or binaural) prescribed as a result of an exam
	• Ear molds as necessary to maintain optimal fit
	• The hearing aid instruments, including bone conduction hearing devices and the initial assessment, adjustment and auditory training
	• Hearing aid rental while the primary unit is being repaired
	• The initial batteries, cords and other necessary ancillary equipment
	• A warranty, when provided by the manufacturer
	• A follow-up consultation within 30 days following delivery of the hearing aids with the provider
	• Auditory training, fitting (including adjustment), repairs, servicing, and alteration of hearing aid equipment purchased under this benefit

What is excluded? (PBC HMO pays 0%)	• Hearing aids purchased before your effective date of coverage under this plan. • Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids. • Hearing aids that exceed the specifications prescribed for correction of hearing loss. • Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended. • Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

Additional Information

For the purpose of this benefit, coverage for members under 18 years of age is available only after the member has received medical clearance within the preceding six months from:

- An otolaryngologist for an initial evaluation of hearing loss; or
- A licensed physician, which indicated there has not be a substantial change in clinical status since the initial evaluation by an otolaryngologist.

Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies

Medical products used to regain functionality or treat a medical condition.

Important things to know:
Check with PBC HMO before buying or renting items

- Equipment and supplies are covered only when a provider states in writing that they are needed.
  - Not all equipment or supplies are covered.
  - Prior authorization may be required.
- You must buy HME from approved providers.
  For a list of providers, visit FindCare at premera.com/sebb or call customer service.
- You can rent HME, up to the purchase price. After that, you pay 100% of costs out of pocket.
- Sales tax, shipping and handling costs apply to any limit if billed and paid separately.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Home medical equipment, orthotics, prosthetics, and supplies	No limit	Deductible, then 20% coinsurance	Not covered
Foot orthotics and therapeutic shoes (orthopedic shoes and shoe inserts) (diabetes-related: no limit)	$300 / calendar year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**External Prosthetics and Orthotic Devices:** To replace, correct, or straighten a body limb. **Home Medical Equipment and supplies** (fitting costs and sales tax) such as: • Wheelchairs. • Hospital beds. • Traction equipment. • Crutches. • Ventilators. • Insulin pump / blood glucose monitor and supplies. **Orthopedic Shoes and Shoe Inserts:** For the treatment of complications from diabetes or other medical disorders that cause foot problems. **Medical Vision Hardware:** For members to correct vision due to medical eye conditions such as: • Corneal ulcer, abrasion, or recurrent erosion. • Bullous keratopathy. • Tear film insufficiency. • Aphakia. • Sjogren's disease. • Congenital cataract. • Keratoconus. • Progressive high (degenerative) myopia. • Irregular astigmatism. • Aniridia. • Aniseikonia. • Anisometropia. • Pathological Myopia. • Post traumatic disorders.
What is excluded? (Insurance pays 0%)	• Supplies or equipment not primarily intended for medical use. • Special or extra-cost convenience features. • Items such as exercise equipment and weights. • Physical changes to your house or personal vehicle (like elevators). • Over-bed tables, vision aids, and telephone alert systems. • Non-wearable defibrillators, trusses, and ultrasonic nebulizers • Over-the-counter orthotic braces and/or cranial banding. • Blood pressure cuffs/monitors (even if prescribed by a physician). • Bed-wetting (enuresis) alarm. • Compression stockings which do not require a prescription. • Orthopedic shoes used for sport, recreation, or similar activity. • Penile prostheses. • Hair prostheses, such as wigs or hair weaves, transplants and implants.
	• See ***Rehabilitation Therapy*** for additional benefit information.

Related benefit information	• See ***Prescription Drugs*** for some diabetic testing supplies which can be purchased in a pharmacy • See ***Surgery*** for prosthetics, intraocular lenses, equipment, or devices which require surgery • Breast pumps are covered under ***Preventive Care.*** • Not all equipment or supplies are covered. Some items need prior authorization from us (See ***Prior Authorization***).

Hospice and Palliative Care

A facility or program that provides supportive care and symptom management. Hospice is specific to terminally ill members, while palliative care can be provided to others with serious illness.

Important things to know:

- Care is covered when a provider states in writing that care is needed.
- Inpatient care is only covered when it's an alternative to hospitalization or a skilled nursing facility.
- After the lifetime maximum for respite care is met, you pay 100% of costs out of pocket.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Home visits	No limit within the 6-month lifetime maximum	Deductible, then 20% coinsurance	Not covered
Respite care	240 hours within the 6-month lifetime maximum	Deductible, then 20% coinsurance	Not covered
Inpatient facility care	30 days	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Nursing care provided by or under the supervision of a registered nurse. • Medical social services provided by a medical social worker who is working under the direction of a physician; this may include counseling for the purpose of helping you and your caregivers to adjust to the approaching death. • Services provided by a qualified provider associated with the hospice program. • Short term inpatient care provided in a hospice inpatient unit or other designated hospice bed in a hospital or skilled nursing facility; this care may be for the purpose of occasional respite for your caregivers, or for pain control and symptom management. • Home medical equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness. • Home health aide services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care. • Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills. • Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms. • Palliative care for members facing serious, life-threatening conditions, including expanded access to home based care and care coordination. Participation in palliative care is usually approved for 12 months at a time and may be extended based on the member's specific condition.
Whose services are covered?	When provided by a hospice that is Medicare-certified or is licensed or certified by the state it operates in, the following are covered: • A registered nurse. • A licensed practical nurse. • A licensed physical or occupational therapist. • A certified respiratory therapist. • A certified speech therapist. • A home health aide directly supervised by one of the above listed providers. • A licensed social worker.
What is excluded? (PBC HMO pays 0%)	• Over-the-counter drugs, solutions, and nutritional supplements. • Services provided to someone other than the ill or injured member. • Services of family members or volunteers. • Services, supplies or providers not in the written plan of care or not named as covered in this benefit. • Non-medical services, such as spiritual, legal or financial counseling. • Normal living expenses, such as food, clothing, and household supplies; housekeeping services.

Hospital

A hospital is a licensed facility where providers supervise and administer acute care.

Important things to know:

- A typical hospital visit results in multiple charges for things like the facility, professional services, and tests used to diagnose your condition. You may receive separate bills for each charge.
- PBC HMO must approve all planned inpatient stays before you enter the hospital. See ***Prior Authorization*** for details. Typically, a stay is considered inpatient when you're in the hospital for 24 hours or more.
- Emergency visits don't require approval beforehand.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient facility charges	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient facility charges	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Inpatient room and board. • Provider services. • Intensive care or special care units. • Operating rooms, procedure, and recovery rooms. • Surgical supplies and anesthesia. • Drugs, blood, medical equipment, and oxygen for use in the hospital. • X-ray, lab, and testing billed by the hospital. • Medically necessary detoxification.
What is excluded? (PBC HMO pays 0%)	• Any days of inpatient care beyond what is medically necessary to treat the condition. • Hospital stays that are only for testing, physical exams, checkups, medical evaluations, or observations, **unless**:

	• The tests can't be done without the use of a hospital. • You have a medical condition that makes hospital care medically necessary.
Related benefit information	• Services received from out-of-network providers are not covered under this plan, except services required by federal or state law. See ***How Providers Affect Your Costs*** for details. • Non-emergency inpatient hospitalizations require prior authorization. See ***Prior Authorization*** for details.

Infusion Therapy

Infusion therapy is when fluids or medications are administered into the vein through a needle or catheter as part of a course of treatment.

Examples of infusion include:

- Drug therapy.
- Pain management.
- Total or partial parenteral nutrition (TPN or PPN).

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Infusion therapy treatments	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Outpatient facility services • Professional services provided in an office, home, or infusion clinic/center • Prescription drugs, supplies and solutions used during infusion therapy
What is excluded? (PBC HMO pays 0%)	• Over-the-counter drugs and solutions. • Over-the-counter nutritional supplements. • IV fluids at a “medispa”.
Related benefit information	• Some services require prior approval. See ***Prior Authorization*** for details. • See ***Prescription Drugs*** related to medications.

Injectable Drug Therapies

Therapeutic injections and related supplies to relieve pain and treat medical conditions when provided in a provider's office.

Important things to know:

- Some injections require approval from PBC HMO before they happen. See ***Prior Authorization*** for details.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Injectable drug therapies	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Shots given in the provider's office • Supplies used during the visit, such as serums, needles, and syringes • Three teaching doses per self-administered injectable drug per lifetime
Related benefit information	• See ***Prescription Drugs*** for other drug coverage, including self administered and specialty drugs. • Some services require prior approval. See ***Prior Authorization*** for details. • For immunization benefits, see ***Preventive Care.*** • For allergy shot benefits, see ***Allergy Testing and Treatment.*** • See ***Infusion Therapy*** for drug therapy and pain management benefit details.

Massage Therapy

Massage therapy to treat a covered illness, injury or condition.

Important things to know:

- Services must be provided by a massage practitioner who is licensed or certified as required by the state in which services are provided.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Infusion therapy treatments	24 visits / year	$10 copay, deductible waived	Not covered

Benefit Overview

What services are included?	• Services within the scope of the massage practitioner license or certification
What is excluded? (PBC HMO pays 0%)	• Massage therapists are not covered under any other benefits of this plan.
Related benefit information	• See the ***Rehabilitation Therapy*** benefit for coverage of physical and other rehabilitative therapies. Massage therapy by other providers is not covered under this benefit.

Mastectomy and Breast Reconstruction

Mastectomy and breast reconstruction benefits are provided when necessary due to disease, illness, or injury.

Important things to know:

- A typical reconstruction may result in multiple charges for things like the facility, professional services, and surgery services. You may receive separate bills for each charge.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Mastectomy and breast reconstruction	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**Procedures to treat the following:** • Breast disease or cancer, including severe fibrocystic breast disease that is unresponsive to medical therapy. • Breast injury or trauma. • Reduce risk of developing breast cancer (prophylactic mastectomy). **Breast reconstruction** • Reconstruction of the breast on which a mastectomy was performed, and the unaffected breast to restore symmetry. • Breast reduction, when medically necessary. • Physical complications of all stages of mastectomy, including lymphedema treatment and supplies. • Inpatient care. • Nipple tattoos are covered only if performed by a licensed healthcare provider.
What is excluded? (PBC HMO pays 0%)	• All services performed by tattoo artists are not covered.
Related benefit information	• Planned hospital admissions require prior authorization. See ***Prior Authorization*** for details. • See ***Home Medical Equipment (HME) Orthotics, Prosthetics and Supplies*** for mastectomy bras and prosthesis.

	• Mastectomy and breast augmentation for gender affirming care are addressed under ***Gender Affirming Care***.

Maternity Care

Care during pregnancy and childbirth, and immediately after the baby is born. Routine pregnancy exams and tests are covered under ***Preventive Care***. This plan covers birth doula services. Benefits will include one doula attended delivery and four antepartum/postpartum visits up to a maximum benefit of $1,000 per pregnancy. Coverage will include the same cost shares as other medical services, to include appliable deductibles and coinsurance. Before seeking doula services, you must first be examined by a licensed physician, registered nurse or midwife and have a confirmed pregnancy.

Cost Overview

Important things to know:

- A typical birth results in multiple charges for things like the facility, professional services, and diagnostic tests for both you and your baby. You may receive separate bills for each charge.
- You must add your newborn or newly adopted child to your health plan for enrollment in the plan. This is not automatic.
- Hospital stays for maternity care are:
  - No less than 48 hours for a vaginal delivery; or
  - No less than 96 hours following a cesarean section.
  - The attending provider will determine an appropriate discharge time in consultation with the member.
- Breast pumps, breastfeeding support, and screening for postpartum depression are covered. Please call PBC HMO customer service for a list of approved providers.

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Professional care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient hospital and short-stay hospitals	No limit	Deductible, then 20% coinsurance	Not covered
Abortion	No limit	No charge	Not covered
Birth Center	No limit	Deductible, then 10% coinsurance	Not covered

Benefit Overview

What services are included?	• Diagnostic and screening procedures, and genetic counseling • Delivery of your baby, including home birth • Additional post-delivery care, when the attending provider decides it's necessary, and it's based on accepted medical practice • Medically necessary donor human milk obtained from a milk bank for inpatient use when ordered by licensed healthcare provider • Abortion • Medically necessary donor human milk for inpatient use is covered at no charge
Whose services are covered?	• Physician (M.D. or D.O.), or a physician's assistant. • Certified nurse midwife (C.N.M). • A licensed midwife. • Advanced registered nurse practitioner (A.R.N.P). • Doula services for in person, phone, and email support during the delivery and the four visits for antepartum/postpartum services, birth support and lactation support

What is excluded? (PBC HMO pays 0%)	• Assisted reproduction technologies such as:
	  • Artificial insemination or in-vitro fertilization.
	  • Services to make you more fertile or for multiple births.
	  • Reversing sterilization surgery.
	• Apprentice doulas
	• Babysitting or doing household chores
	• Travel time
	• Any other services not listed as covered doula services, above

Related benefit information	• Certain laboratory services and ultrasounds are billed separately. See ***Diagnostic X-ray, Lab and Imaging.*** • Hospital care may be billed separately. See ***Hospital***. • Depression screening for pregnant and postpartum members are covered as preventive care. See ***Preventive Care***. • For routine prenatal and postnatal exams and tests, see ***Preventive Care***. • Non-emergency inpatient hospitalizations require prior authorization. See ***Prior Authorization*** for details. • See ***Newborn Care***. • Doula's must be licensed in states that require a license. Otherwise, if the state does not require a license, then the doula must have a current certification under a recognized doula certification organization (examples include DONA International and PALS Doulas). You must pay for all doula expenses yourself and submit a Claim Reimbursement Form to us. You can get Claim Reimbursement Forms on our website at premera.com/sebb. You can also call us for a copy of the form.

Medical Foods

Nutrients given orally or via feeding tube to provide complete nutrition when a person can't eat, swallow, or otherwise absorb foods, due to a specific medical condition, for example phenylketonuria (PKU). Medical foods must be prescribed and supervised by doctors or other health care providers.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Medical foods	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**Dietary replacement to treat:** • Inborn errors of metabolism. • A severe allergy to most foods based on white blood cells in the stomach and intestine that cause inflammation (eosinophilic gastrointestinal associated disorder). • Other severe conditions when your body can't take in nutrients from food in the small intestine. • Disorders where you can't swallow due to a blockage or muscular problem and need to be fed through a tube.
What is excluded? (PBC HMO pays 0%)	• Food and nutritional supplements, and specialized infant formulas (other than those prescribed to treat the conditions listed above) • Lactose-free or gluten-free foods

Medical Transportation

Planned travel and lodging for a scheduled and pre-approved service.

Important things to know:

- Prior approval is required for all travel reimbursement. See ***Prior Authorization***.
- One companion needed for the member's health and safety is covered.
- For medically necessary care, a second companion is covered for a child under age 19.
- The member receiving medical transportation must live more than 50 miles away from the facility unless treatment protocols require them to be closer.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
For Transplants	$7,500 limit per transplant	Deductible, then 0% coinsurance	In-network deductible, then 0% coinsurance
Cellular Immunotherapy and gene therapy	$7,500 per episode of care for travel lodging maximum	No charge	No charge

Benefit Overview

What services are included?	• Ferry transportation from the member's home. • Mileage expenses for the member's personal vehicle. • Lodging expenses at commercial establishments, including hotels and motels, between the home and medical facility where the service will be provided. • Ground transportation, car rental, taxi fares, and parking fees for the member and a companion (when covered) between the hotel and medical facility where services will be provided. **Air Transportation** • Air travel expenses between the member's home and medical facility where services will be provided. • Unrestricted coach class. • Flexible and fully refundable round-trip airfare from a licensed commercial carrier.
What is excluded? (PBC HMO pays 0%)	• Charges and fees for booking changes. • Cancellation fees. • First class airline fees. • International travel. • Lodging at any establishment that is not commercial. • Meals. • Personal care items. • Pet care, except for service animals.

	• Phone service and long-distance calls. • Reimbursement for mileage rewards or frequent flier coupons. • Reimbursement for travel before contacting PBC HMO and receiving prior authorization. • Travel for medical procedures not listed above. • Travel in a mobile home, RV, or travel trailer. • Travel to providers outside the network or that have not been designated by PBC HMO to perform the services. • Travel related to participation in a clinical trial. • Travel insurance.
Related benefit information	• See ***Transplants*** for covered transplants. • See ***Ambulance*** for emergent and planned non-emergent transportation services.

Additional Information

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The mileage limits and requirements can change if IRS regulations change. Visit irs.gov for details. This summary is not and shouldn't be assumed to be tax advice.

Reimbursement of Travel Claims
A separate Claim Reimbursement Form is needed for each patient and each commercial carrier or transportation service used. You can find this form on **www.premera.com/sebb** or call customer service to get a copy.

To be reimbursed, attach the following documents to the Claim Reimbursement Form:

- Receipts for all covered travel expenses.
- A copy of the detailed itinerary issued by the transportation service, travel agency, or online travel website. **The itinerary must include:**
  - Passenger names.
  - Dates of travel.
  - Total cost of travel.
  - Origination and final destination points.

Note: Credit card statements or other payment receipts are not acceptable forms of documentation.

Mental Health Care

Evaluation and/or treatment meant to manage or lessen effects of a mental health condition.

Important things to know:

- Prescribed medications are covered under ***Prescription Drugs.***
- Inpatient care is only covered as long as it's medically necessary.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	$10 copay, deductible waived	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient and residential facility care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are covered?	• Inpatient care. • Outpatient care. • Residential facility care. • Individual or group therapy. • Family therapy, including couples therapy. • Laboratory and testing services. • Take home drugs you get in a facility. • Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders. • Services provided in your home, when medically appropriate. • Applied behavioral analysis (ABA) therapy (see ***Additional Information***).
	• A state licensed or approved facility, program, or agency that provides mental health services within the scope of their state licensure.

Whose services are covered?	• A state licensed or certified clinician that provides mental health services within the scope of their state licensure or certification. • Any other provider listed under "provider" in ***Definitions*** who is licensed or certified in the state where care is provided, and who is providing care within the scope of their license. • Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care. • See ***Additional Information*** for who can provide ABA services.

What is excluded? (PBC HMO pays 0%)	• Evaluations that are not for the purpose of identifying or planning treatment of covered mental health disorders, including evaluations for custody, competency, forensic, vocational, and educational or academic placement.
	• Recreational, camp and activity-based programs. These programs are not medically necessary and include:
	  • Gym, swim and other sports programs, camps and training
	  • Creative art, play and sensory movement and dance therapy
	  • Recreational programs and camps
	  • Hiking, tall ship and other adventure programs and camps
	  • Boot camp programs and outward bound programs
	  • Equine programs and other animal-assisted programs and camps.
	  • Exercise and maintenance-level programs
	• Diagnosis and treatment of sexual dysfunction, regardless of origin or cause, surgical, medical or psychological treatment, including drugs, medications or penile or other implants.

Related benefit information	• See ***Psychological and Neuropsychological Testing*** for additional benefit information. • See ***Substance Use Disorder***. • See ***Prescription Drugs***. • See ***Exclusions and Limitations*** for other services that are not covered, such as recreational, camp, and activity programs and sexual dysfunctions. • See ***Virtual Care*** for information related to virtual care services. • This plan will comply with federal mental health parity requirements.

Additional Information

What services are covered as part of "applied behavioral analysis (ABA)"?

- Therapy for members with autistic disorder, autism spectrum disorder, Asperger's disorder, childhood disintegrative disorder, pervasive developmental disorder, or Rett's disorder.
- Treatment or direct therapy for identified members and/or family members.
- Initial evaluation and assessment, treatment or intervention, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed.
- Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques.

Whose services are covered as part of "applied behavioral analysis (ABA)"?

- A licensed physician (MD or DO) who is a psychiatrist, developmental pediatrician or pediatric neurologist.
- A licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP).

- A licensed occupational or speech therapist.
- A licensed psychologist (PhD).
- A licensed community mental or behavioral health agency that is state-certified to provide ABA therapy.
- A Board-Certified Behavior Analyst (BCBA), who is state licensed in states that license behavior analysts (like Washington), or certified by the Behavior Analyst Certification Board in states that do not license. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.
- A therapy assistant/behavioral technician/paraprofessional when their services are supervised and billed by a licensed provider or a BCBA.

Neurodevelopmental (Habilitation) Therapy

Neurodevelopmental (habilitation) therapy is therapy that helps a person acquire, improve, or maintain age-appropriate skills that have not yet developed This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental or habilitation therapy.

Important things to know:

- A visit is counted as one treatment for each type of therapy. Multiple visits with the same provider in one day count as one visit. If you see three different providers in one day, that will count as three visits.
- Habilitation therapy is therapy that assists a person to keep, learn or improve skills and functioning for daily living.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Outpatient care	45 visits / year	$40 copay, deductible waived	Not covered
Inpatient care	45 days / year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Physical, speech, and occupational therapy assessments related to treatment. • Outpatient care is covered when the member isn't confined in a hospital or other medical facility.
Whose services are covered?	• Benefits must be provided by a: ○ Physical therapist ○ Occupational therapist ○ Speech language pathologist ○ Any other licensed provider practicing within the scope of their license • Inpatient facility services must be provided and billed by a hospital or rehabilitation facility that meets our clinical standards and will only be covered when services can't be done in a less intensive setting. • Outpatient services must be provided and billed by a hospital or rehabilitation facility that meets our clinical standards, physician, physical, occupational or speech therapist, chiropractor, or naturopath.
	• Gym or swim therapy • Custodial care • Recreational, vocational, or education therapies • Exercise or maintenance level programs

What is excluded? (PBC HMO pays 0%)	• Social or cultural therapy • Treatment that isn't actively engaged in by the ill, injured, or impaired member
Related benefit information	• See ***Rehabilitation Therapy, Psychological and Neuropsychological Testing*** for details on when to apply that benefit. • See ***Mental Health Care*** for therapies provided for mental health conditions, such as autism. • If you are using ***Rehabilitation Therapy*** for the same treatment reason, this benefit can't be applied at the same time. Once the maximum has been met for either, no additional benefits are available. • You must get a prior authorization from us before you get inpatient treatment. See ***Prior Authorization*** for details.

Newborn Care

Care your baby gets during and immediately after birth.

Important things to know:

- Newborn care is not covered at 100%. See ***Cost Overview*** below.
- Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive maternity care benefits under this plan.
- To continue benefits beyond the 3-week period, see ***Eligibility and Enrollment.***
- Your newborn is a new person on your health plan, who may need to meet their own deductible.
- A typical birth results in multiple charges for things like the facility, professional services, and tests used to diagnose your newborn's condition. You may receive separate bills for each charge.
- You must add your newborn or newly adopted child to your health plan for enrollment in the plan. This is not automatic.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Newborn care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Inpatient newborn care, including routine newborn exams while the child is in the hospital after birth • Circumcision The following services are covered, when ordered by the attending provider and based on accepted medical practice: • Nursery care (including NICU) • Follow-up care at home from the attending provider, a home health agency, or a registered nurse • Any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury
Whose services are covered?	• Physician (MD or DO), or a physician's assistant. • Certified nurse midwife (CNM). • A licensed midwife. • Advanced registered nurse practitioner (ARNP).
Related benefit information	• See ***Preventive Care*** for information about visiting the provider's office after you take your newborn home, including immunizations and well-child exams. • Certain laboratory services and ultrasounds are billed separately. See ***Diagnostic X-ray, Lab and Imaging.***

Orthognathic Surgery (Jaw Augmentation or Reduction)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic
surgery) are provided.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Orthognathic Surgery	No limit	Deductible, then 20% coinsurance	Not covered
Office and clinic visits	No limit	See Professional Visits and Services	Not covered
Outpatient surgery facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Exams • Consultations • Diagnostic Services • Orthognathic surgery • Facility Charges
What is excluded? (PBC HMO pays 0%)	• Procedures to lengthen or shorten the jaw for cosmetic purposes.
Related benefit information	• For gender affirming surgery benefits, see ***Gender Affirming Care***. • See ***Hospital*** for your facility cost share amounts. • Services rendered at an ambulatory surgical center are covered under ***Ambulatory Surgical Center.***

Prescription Drugs

This benefit covers prescription drugs that are approved by the U.S. Food and Drug Administration (FDA) that your provider prescribes, and you get from a licensed pharmacy for take-home use.

Important things to know:

- This plan uses a formulary drug list. **Please refer to your ID card for your formulary drug list.**
- If your copay is higher than the cost of a drug, you will always pay the lower amount.
- Retail pharmacy coverage is available up to a 90-day supply for prescription drugs. The cost share will be calculated for each 30-day supply.
- You can find a list of covered drugs (formulary drug list) on **p**remera.com/sebb. Certain drugs need prior approval, see ***Prior Authorization*** for more details.
- A covered drug you may be taking can change to a different cost sharing tier or become not covered. This can happen at any time throughout the year, if this does occur, we'll notify you in writing 60 days before the change happens.
- Some preventive drugs have limits on how often you and/or who should get them. The limits are often based on your age or gender. After one of these limits is reached, these drugs are not covered in full and you may have to pay more out-of-pocket costs.

Cost Overview

What is covered?	What will I pay? In-network	Out-of-network
Retail Pharmacy		
Preferred generic drugs	$9 copay (per 30-day supply)	Not covered
Preferred brand name drugs	$40 copay (per 30-day supply)	Not covered
Non-preferred generic and brand name drugs	50% coinsurance (per 30-day supply)	Not covered
Mail-Order Pharmacy		
Preferred generic drugs	$27 copay (per 90-day supply)	Not covered

Preferred brand name drugs	$120 copay (per 90-day supply)	Not covered
Non-preferred generic and brand name drugs	50% coinsurance (per 90-day supply)	Not covered
Specialty Pharmacy		
Preferred Specialty drugs (per prescription or refill)	$75 copay (per 30-day supply)	Not covered
Non-Preferred specialty drugs (per prescription or refill)	50% coinsurance (per 30-day supply)	Not covered

Other covered Drugs and Services		
Needles and syringes purchased with diabetic drugs	No charge	Not covered
Nicotine Habit-Breaking Drugs	No charge	Not covered
Drugs on the Affordable Care Act's preventive drug list	No charge	Not covered
Oral anticancer drugs	No charge	No charge
Contraceptives	No charge	Not covered

Benefit Overview

What services are included?	• FDA approved formulary drugs. Federal law requires a prescription for these drugs. They are known as "legend drugs". • All FDA-approved HIV antiviral drugs required to be covered by state or federal law • FDA-approved prescription hormone therapy (does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists); up to 12-month refill supply of prescription hormone therapy that can be safely stored at room temperature • Glucagon and allergy emergency kits. • Inhalers, supplies and peak flow meters. • Some drugs that treat complex or rare health conditions may only be available at specialty pharmacies. • Prescribed preventive drugs required by the Affordable Care Act. • Compound medications that contain at least one covered prescription drug. • Certain prescription and generic over-the-counter drugs to break a nicotine habit. • Drugs associated with an emergency medical condition. **Epinephrine autoinjectors** • Prescribed epinephrine autoinjectors for the treatment of allergic reaction. (Your cost shares for at least one covered epinephrine autoinjector product containing at least two autoinjectors will not exceed $35, not subject to the deductible, if any. Cost shares for covered prescription epinephrine autoinjectors apply towards the deductible, if any.) **Asthma Inhalers** • Prescribed asthma inhalers for the treatment of asthma. (Your cost shares for covered prescription asthma inhalers for at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination that is FDA approved for the treatment of asthma will not exceed $35 per 30-day supply of the drug, not subject to the deductible, if any. Cost shares for covered prescription asthma inhalers apply towards the deductible, if any.) **Diabetic Drugs and Supplies** • Prescribed drugs for shots that you give yourself, such as insulin. (Your cost-shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug, not subject to the deductible. Cost-shares for covered prescription insulin drugs apply towards the deductible, if any.*)* • Needles, syringes, alcohol swabs, test strips, testing agents, blood glucose monitors, and lancets **Oral anticancer medication** • Drugs you take by mouth that can be used to kill cancer cells or slow their growth. This benefit only covers the drugs that you get from a pharmacy; those you get at a hospital or provider office are covered through your medical benefit rather than the pharmacy benefit. **Human growth hormone**

	• Human growth hormone is covered only for medical conditions that affect growth. It is not covered when the cause of short stature is unknown. Human growth hormone is a specialty drug. **Contraceptives** • All FDA-approved prescription and over-the-counter oral contraceptive drugs, supplies, and devices, including emergency contraceptive, are required to be covered by state and federal law. Over-the-counter supplies and devices must be bought at the pharmacy counter.
What is excluded? (PBC HMO pays 0%)	• Over-the-counter drugs and supplies that aren't listed above as covered, even if you have a prescription. • Non-formulary drugs. • Blood or blood derivatives. See ***Blood Products and Services***. • Drugs used to improve your looks, such as drugs to increase hair growth or alter the appearance of your skin • Drugs for experimental or investigational use. • Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and healthcare provider administered injectable medications, unless included in the formulary drug list • More refills than the number prescribed, or any refill dispensed more than one year after the prescriber's original order. • Drugs for use while you're in a health care facility or provider's office, unless included in the formulary drug list • Replacement of lost or stolen medication. • Drugs to treat sexual dysfunction. • Drugs to manage your weight. • Drugs for fertility treatment or assisted reproduction procedures.
Related benefit information	• For shots or devices from your provider, see ***Preventive Care.*** • For coverage related to medical equipment and supplies, see ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies.*** • For Blood or blood derivatives coverage, see ***Blood Products and Services.*** • See ***Infusion Therapy*** and ***Injectable Drug Therapies*** for solutions and drugs that you get through a shot, intravenous needle, catheter, or a feeding tube. • For cell and gene therapy, see ***Cellular Immunotherapy and Gene Therapy.*** • To learn more about what experimental or investigational means, see ***Definitions.*** • Certain drugs need prior approval. See ***Prior Authorization***.

Getting Your Prescriptions Filled

Pharmacy	Supply Limit	What to do
In-network retail pharmacies	Non-specialty drugs: Up to 90-days at a time Specialty drugs: Up to 30-days at a time	• Pay the amount you're responsible for at the pharmacy. The cost share will be calculated for each 30-day supply. • Ask your provider to prescribe up to a 90-day supply of the drug you need.
In-network specialty pharmacies	Up to 30 days at a time	• Pay the amount you're responsible for at the pharmacy. If the drug dosing frequency (how often the drug is taken) requires more than a 30-day supply, the cost share will be calculated for each 30-day supply.

In-network mail-order pharmacy	Non-specialty drugs: Up to 90-days at a time
	Specialty drugs: Up to 30-days at a time
		• Allow 2 weeks for your prescription to be filled
		• Ask your provider to prescribe up to a 90-day supply
		• Fill your prescription one of three ways:
		  ○ Download the "Home Delivery Order Form" on [premera.com] and send via mail
		  ○ Call PBC HMO customer service
		  ○ Sign in to [premera.com] go to:
		  ▪ Prescriptions, then
		  ▪ Manage prescriptions, then
		  ▪ Order and refill

Note: Out-of-network retail, mail order, and specialty pharmacies are not covered.

Additional Information

Off-label Use

- The U.S. Food and Drug Administration (FDA) approves prescription drugs for specific health conditions or symptoms. Some drugs are prescribed for uses other than those the FDA has approved. This is known as "off-label use".
- The American Medical Association Drug Evaluation.
- The United States Pharmacopoeia-Drug Information.
- Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner.
- The Federal Secretary of Health and Human Services.

If not recognized by one of the standard reference compendia cited above, then the off-label use must be recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity, and reliability by independent, unbiased experts).

Note: Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Formulary Drug List

This benefit uses a specific list of covered prescription drugs, sometimes referred to as a "formulary drug list." Our Pharmacy and Therapeutics Committee, which includes providers from the community, frequently reviews current medical studies and pharmaceutical information. The Committee makes recommendations on which drugs are included on our formulary drug lists. The formulary drug lists are updated quarterly based on the Committee's recommendations.

- The formulary drug list includes generic, brand name, and specialty drugs. Consult the List of Covered Drugs (formulary drug list) on our website or contact customer service for a complete list of your plan's covered prescription drugs.
- Drugs not included in the formulary drug list (non-formulary drugs) are not covered by this plan.

Generic Drug Substitution

This plan requires the use of appropriate generic drugs (as defined below). When available, a generic drug will be dispensed in place of a brand name drug. If there is no generic equivalent, you pay only the applicable brand name cost-share. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you will have to pay the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Please ask your pharmacist about the higher costs you will pay if you select a brand name drug.

A "generic drug" is a prescription drug manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have an AB rating from the U.S. Food and Drug Administration (FDA). The FDA considers them to be therapeutically equivalent to the brand name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

This benefit also covers "biological products." Examples are serums and antitoxins. Generic drug substitution applies to biological products.

Exceptions You or your provider may ask that the plan cover a brand name drug instead of a generic equivalent without a penalty. To waive the penalty, your provider must show that 1 of 3 things is true:

- You cannot tolerate the generic equivalent drug
- The drug is not safe or effective for your condition
- The dosage you need is not available in a generic equivalent drug.
- If your request is approved, you pay only the applicable brand name cost-share. If your request is not approved and you choose to purchase the brand name drug, you will pay the penalty described under ***Generic Drug Substitution*** above

Exceptions Request for Non-Formulary Drugs

You or your provider may request that you get a non-formulary drug or dose that is not on the formulary drug list either in writing, electronically, or by telephone. Under some circumstances, such as the ones listed below, a non-formulary drug may be covered if one of the following is true:

- There is no formulary drug or alternative available.
- You cannot tolerate the formulary drug.
- The formulary drug or dose is not safe or effective for your condition.

How to request an Exception

1) Your provider must give us a written or oral statement providing a justification in support of the need for the non-formulary drug to treat your condition, including a statement that all formulary drugs on any tier will be (or have been) ineffective, and would not be as effective as the non-formulary drug, or would have adverse side effects.

2) We will review your request and let you or your provider know within 72 hours in writing if it is approved. If approved, your cost will be as shown on the ***Covered Services*** for formulary drugs and

will be covered for the length of time outlined in the approval letter. If your request is not approved and you choose to purchase the non-formulary drug, the drug will not be covered.

Expedited Exceptions Request for Non-Formulary Drugs

If exigent circumstances exist (description follows), you or your provider may request an expedited review for a non-formulary drug or a dose that is not on the formulary drug list. Exigent circumstances include when you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum body function or when you are undergoing a current course of treatment using a non-formulary drug. In addition to your provider's justification for the non-formulary drug as described above, your provider will need to give us an oral or written statement that confirms that an exigency exists, including the basis for the exigency—the harm that could reasonably come to you if the requested non-formulary drug was not provided within the timeframes of the standard exceptions request. We will respond to the request within 24 hours of receipt of the required information from the provider.

External Review for Non-Formulary Drugs

If you disagree with our decision, you have the right to an additional review through an Independent Review Organization (IRO). An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for this review.

We will let you and your provider know the decision within 72 hours (24 hours in the case of an expedited review). If the IRO grants your request for an exception, you can review your cost in ***Covered Services*** for formulary generic and brand name drugs. The IRO's granted exception will be in effect for the length of time outlined in the approval letter.

Pharmacy Management

Sometimes benefits for prescription drugs may be limited to one or more of the following:

- A specific number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis.
- Certain drugs from certain pharmacies, or you may need to get prescriptions from an appropriate medical specialist or a specific provider.
- Step therapy, meaning you must try a generic drug or a specified brand name drug first.
- Drug synchronization, meaning the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. Cost-shares are adjusted if the fill is less than the standard refill amount in compliance with state law.

These limitations are based on medical criteria, the drug maker's recommendations, and the circumstances of the individual case. They are also based on U.S. Food and Drug Administration guidelines, published medical literature and standard medical references.

Dispensing Limits

Benefits are limited to a certain number of days' supply as shown in ***Covered Services***. Sometimes a drug maker's packaging may affect the supply in some other way. We will cover a supply greater than normally allowed under your plan if the packaging does not allow a lesser amount. Exceptions to this limit may be allowed as required by law. For example, a pharmacist can authorize an early refill of a prescription for topical ophthalmic products in certain circumstances. You must pay a copay for each limited days' supply.

Preventive Drugs

Benefits for certain preventive care prescription drugs will be as shown in ***Covered Services*** when received from network pharmacies. Contact customer service or visit our website to inquire about whether a drug is on our preventive care list.

Using In-network Pharmacies

When you use an in-network pharmacy, always show your PBC HMO ID Card. As a member, you will not be charged more than the allowed amount for each prescription or refill. The pharmacy will also submit your claims to us. You only have to pay the deductible, copay or coinsurance as shown in ***Covered Services***.

If you do not show your PBC HMO ID Card, you will be charged the full retail cost. Then you must send us your claim for reimbursement. Reimbursement is based on the allowed amount. See ***How Do I File A Claim?*** For instructions.
This plan does not cover prescription drugs from out-of-network pharmacies.

Specialty Pharmacy Programs

The Specialty Pharmacy Program includes drugs that are used to treat complex or rare conditions. These drugs need special handling, storage, administration, or patient monitoring. This plan covers these drugs as shown in ***Covered Services***.

Specialty drugs are high-cost often self-administered drugs. They are used to treat conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis or growth disorders (excluding idiopathic short stature without growth hormone deficiency).

To find our in-network specialty pharmacies, visit the pharmacy section of our website at premera.com/sebb or call customer service for more information.

Drug Discount Card Program

In some cases, you may pay less for covered drugs than what's shown in the Cost Overview if our pharmacy program finds a discount or coupon resulting in a lower drug price.

Your Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs that are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call customer service. The phone numbers are shown in ***Contact Information***.

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Questions and Answers About Your Prescription Drug Benefits

Question	Answer
Does this plan exclude certain drugs my provider may prescribe, or encourage substitution for some drugs?	Your prescription drug benefit uses a formulary drug list. We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the formulary drug list. This plan doesn't cover certain categories of drugs. These are listed above under "What's Not Covered." Non-formulary drugs may be covered only on an exception basis for members meeting medical necessity criteria. Certain formulary drugs are subject to prior authorization. As part of this review, some prescriptions may require additional medical

	information from the prescribing provider, or substitution of equivalent drug. See ***Prior Authorization*** for details.
When can my plan change the formulary drug list? If a change occurs, will I have to pay more to use a drug I had been using?	The formulary drug list is updated frequently throughout the year. See "Formulary Drug List" above. If changes are made to the formulary drug list that may negatively impact your cost share, you will receive a letter advising you of the change.
What should I do if I want a change from limitations, exclusions, substitutions, or cost increases for drugs specified in this plan?	The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can't be changed. Provisions regarding substitution of some drugs are described above in question 1. You can appeal any decision you disagree with. See ***Complaints and Appeals*** or call our customer service department at the telephone numbers listed in ***Contact Information*** for information on how to initiate an appeal.
How much do I have to pay to get a prescription filled?	The amount you pay for covered drugs dispensed by a retail pharmacy, mail-order pharmacy or specialty pharmacy is described in ***Covered Services***.
Do I have to use certain pharmacies to pay the least out of my own pocket under this plan?	Yes. You only receive benefits when you have your prescriptions filled by participating pharmacies. The majority of pharmacies in Washington are part of our pharmacy network. You can find a participating pharmacy near you by consulting your provider directory or calling the Pharmacy Locator Line at the toll-free telephone number found on the back of your PBC HMO ID card.
How many days' supply of most medications can I get without paying another copay or other repeating charge?	The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the mail-order pharmacy benefit are described in the "Dispensing Limit" provision above. Benefits for refills will be provided only when the member has used a specific amount of a supply of a single medication. This is known as a refill threshold. This threshold is calculated based on both of the following: • The number of units and days' supply dispensed on the last refill. • The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill. • The refill threshold may vary by the type of medication.
What other pharmacy services does my health plan cover?	This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by a licensed participating pharmacy. Other services, such as diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Preventive Care

Preventive care is a specific set of evidence-based services expected to prevent future illness. It is performed for routine screening purposes when you do not have signs or symptoms of a condition. These services are based on guidelines established by government agencies and professional medical societies.

Services are considered preventive when recommended or required by:

- United States Preventive Services Task Force (A or B rating).
- Centers for Disease Control and Prevention (immunizations).
- Health Resources and Services Administration (screenings and care for women, children, teens).
- Washington state law.
- Washington State Department of Health (immunizations)

Visit **healthcare.gov** for more information.

Important things to know:

- Preventive services provided by in-network providers are covered in full. Services provided by an out-of-network provider are not covered. See ***Prior Authorization***.
- Monitoring a chronic medical condition is not preventive care.
- Even at a preventive visit, you may get non-preventive care:
  - Providers can order a non-preventive test (even alongside preventive tests).
  - If you discuss a sign, symptom, or condition, you may be billed for a regular ***Professional Visit.***
- If a test was ordered to evaluate a sign, symptom, or health concern, it is ***Diagnostic.***
- The maximum number of visits covered is recommended by the United States Preventive Services Task Force, Centers of Disease Control and Prevention, and Health Resources and Services Administration, as applicable.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Screening tests if meeting the above criteria	No limit	No charge	Not covered
Colon cancer screening	No limit	No charge	Not covered
Wellness exams	No limit	No charge	Not covered
Contraceptives and sterilization	No limit	No charge	Not covered

Nutritional counseling and therapy (for specific populations, see below)	No limit	No charge	Not covered
Immunizations in the provider's office	No limit	No charge	Not covered
Seasonal immunizations at a pharmacy or mass immunizer location	No limit	No charge	No charge
Travel immunizations at a travel clinic or county health department	No limit	No charge	No charge
Health education and training (outpatient)	No limit	No charge	Not covered
Nicotine cessation programs	No limit	No charge	Not covered
Diagnostic and supplemental breast exam	No limit	No charge	Not covered

Benefit Overview

What services are included?	**Wellness exams**, including those for school, sports, and jobs **Screening tests and imaging,** such as: • Mammograms (including 3-D). • Pap smears. • Prostate-specific antigen tests. • BRCA genetic tests for women at risk for certain breast cancers. • Diabetes screening. • Hearing screening for all newborns, and regular screenings for children and adolescents as recommended by their provider. **Colon cancer screening** (for high-risk individuals and all individuals 45 years of age or older): • Pre-colonoscopy consultation and exam. • Colonoscopies as follow-up to a positive non-invasive stool-based screening test • Barium enema.

	• Colonoscopy, sigmoidoscopy, and fecal occult blood tests. • If polyps are found during the screening, their removal and lab tests are covered as preventive. • Medically necessary anesthesia. Contraceptive **and t**ubal ligation**:** • Contraceptive devices, shots, and implants, including anesthesia. This plan will cover up to 12-month supply of contraceptive drugs (may be dispensed at a provider's office). • Plan B (emergency contraceptive). • Tubal ligation (other services, like anesthesia, are covered as preventive only if tubal ligation is the primary procedure). **Routine maternity care:** • Routine prenatal exams and tests. • Breastfeeding support and counseling. • Purchase of standard breast pump (bought from approved suppliers). **Call PBC HMO customer service for a list of approved suppliers**. • Rental of hospital-grade breast pump. Outpatient **nutritional counseling and therapy** for obese adults and children, and members at risk for health conditions affected by diet. **Immunizations**, including seasonal and for travel. **Pre-exposure prophylaxis (PrEP)** for members at high-risk for HIV infection. **Post-exposure prophylaxis (PEP)** **Health education and training:** • Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma. • The program or class must take place in an approved setting, like a hospital. **Nicotine habit-breaking programs.**
What is excluded? (PBC HMO pays 0%)	• Gym memberships/fees or exercise classes or programs. • Exams for insurance or work-related disability purposes. • Routine hearing exams. See ***Hearing Care***. • Routine or other dental care.
Related benefit information	• For tests and services to evaluate a sign, symptom or health, see ***Diagnostic, X-ray, Lab and Imaging.*** • See ***Prescription Drugs*** for take-home or over-the-counter items. • See ***Newborn Care*** for routine newborn exams when the child is in the hospital after birth. • If tubal ligation is a secondary procedure, it is still covered as preventive. However, related services like anesthesia are covered under the primary procedure. See ***Hospital*** and ***Surgery.*** • For male sterilization, see ***Surgery.***

Additional Information

Diagnostic breast examination for the purpose of this ***Diagnostic X-ray, Lab, and Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast resonance imaging, advanced imaging (including magnetic resonance imaging and ultrasound), breast ultrasound, or pathology evaluations (including biopsies and consultations) that is used to evaluate an abnormality:

- Seen or suspected from a screening examination for breast cancer; or
- Detected by another means of examination.

Supplemental breast examination for the purpose of this ***Diagnostic X-ray, Lab, and Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is:

- Used to screen for breast cancer when there is no abnormality seen or suspected; and
- Based on personal or family medical history, or additional factors that may increase the member's risk of breast cancer.

Professional Visits and Services

Care by a qualified provider to examine, diagnose, or treat an illness or injury.

Important things to know:
You can get care:

- At a provider's office or other medical setting.
- At home, when medically necessary.
- Virtually (secure chat, text, voice or video). See ***Virtual Care***.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Primary Care office and clinic visits	No limit	$10 copay, deductible waived	Not covered
Office visits for women's health (e.g. gynecologist)	No limit	$10 copay, deductible waived	Not covered
All other professional office and clinic visits (including specialists)	No limit	$40 copay, deductible waived	Not covered

Benefit Overview

What services are included?	• Care by a qualified provider to examine, diagnose, or treat illness or injury. • Second opinions for any covered medical diagnosis or treatment plan.
What is excluded? (PBC HMO pays 0%)	• Hair analysis or non-prescription medicines, such as herbal, naturopathic or homeopathic medicines or devices • Services used to improve your appearance, such as services to increase hair growth or alter the appearance of your skin
Related benefit information	• For preventive services like wellness exams, see ***Preventive Care***. • For surgical procedures performed in a provider's office, surgical suite or other facility, see ***Surgery***. • For mental health conditions, see **Mental Health Care.** • For substance use disorder conditions, see Substance Use Disorder. • Facilities may be billed separately, see ***Hospital***. • Lab tests or images may be billed separately, see ***Diagnostic X-ray, Lab, and Imaging***. • See ***Home Health Care*** and ***Hospice Care*** for care in those settings. • See ***Rehabilitation Therapy***.

Psychological and Neuropsychological Testing

Psychological and neuropsychological evaluation necessary to prescribe an appropriate treatment plan.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Psychological and Neuropsychological testing	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Psychological and neuropsychological testing and scoring • Future re-testing to make sure the treatment is achieving the desired medical result • Interpretation and report preparation necessary to prescribe an appropriate treatment plan
Related benefit information	• For services related to a mental health condition, see ***Mental Health Care***. • See ***Rehabilitation Therapy*** for physical, speech, or occupational therapy assessments related to rehabilitation. • See ***Neurodevelopmental (Habilitation) Therapy*** for therapy assessments related to neurodevelopmental conditions.

Rehabilitation Therapy

Rehabilitation therapy is therapy that helps a person restore or improve a skill needed to perform an activity of daily living that was lost because of an accidental injury, illness, or surgery.

Important things to know:

- You must get approval from PBC HMO before getting treatment at an inpatient rehabilitation center. Services must be prescribed in writing by your provider. The prescription must include site, type of therapy, how long and how often you should get the treatment. See ***Prior Authorization*** for details.
- PBC HMO reviews proposed outpatient physical, occupational therapy for medical necessity before you receive the care. Your first six visits to the therapist are not subject to this review. There is no penalty to you if your provider does not ask for the review before providing additional visits. The review will then be done at the time the claim is submitted.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Outpatient care	45 combined visits / year	$40 copay, deductible waived	Not covered
Inpatient care	45 days / year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**Inpatient Care is covered when:** • It's medically necessary and you cannot get these services in a less intensive care setting. • Provided by a specialized inpatient rehab center (this could be part of a hospital). • The care is part of a written treatment plan prescribed by your provider. **Outpatient Care is covered for:** • Physical, speech, hearing, and occupational therapies, assessments, and evaluations related to rehab • Cochlear implants • Home medical equipment, medical supplies, and devices
Whose services are covered?	Benefits must be provided by a: • Physical therapist • Occupational therapist • Speech language pathologist

	• Any other licensed provider practicing within the scope of their license
What is excluded? (PBC HMO pays 0%)	• Treatment that the ill, injured, or impaired member does not actively take part in • Therapy for flat feet except to help you recover from surgery to correct flat feet • Outpatient rehabilitation therapy virtual care
Related benefit information	• For services related to a mental health condition, see ***Mental Health Care***. • Chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases are covered as any other medical condition and do not accrue to rehabilitation therapy limits. • If you are using ***Neurodevelopmental (Habilitation) Therapy*** for the same treatment reason, this benefit can't be applied at the same time. Once the maximum has been met for either, no additional benefits are available.

Skilled Nursing Facility Care

Medically necessary care in a facility which specializes in rehabilitation, usually to help you transition from a hospital stay to getting home.

Important things to know:

- Your provider must obtain prior authorization for all planned skilled nursing facility stays. See ***Prior Authorization*** for details.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Skilled nursing facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Room and board • Skilled nursing services • Supplies and drugs • Skilled nursing care during some stages of recovery • Skilled rehabilitation provided by physical, occupational, or speech therapists while in a skilled nursing facility • Active supervision by your provider while in the skilled nursing facility
What is excluded? (PBC HMO pays 0%)	• Acute nursing care • Skilled nursing facility stay not immediately following hospitalization • Skilled nursing care outside of a hospital or skilled nursing facility
Related benefit information	• For information about getting care in your home, see ***At-Home Care.*** • For acute nursing care, see ***Hospital.*** • See ***Ambulance*** for transportation services that are covered when going from the hospital to a skilled nursing facility.

Substance Use Disorder

Substance Use Disorder is when the use of alcohol, opioids, or another substance (drug) leads to someone's health being in danger, and/or leads to problems at work, home, or school. Please call customer service for help with finding a provider.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	$10 copay, deductible waived	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient care and residential facility care	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Diagnosis and treatment of substance use disorder • Inpatient and residential treatment and outpatient care to manage or reduce the effects of the alcohol or drug dependence • Individual, family or group therapy • Laboratory and testing services • Take-home drugs you get in a facility • Detoxification, when medically necessary; emergency detoxification is only covered in a hospital • When medically appropriate, services may be provided in your home
Whose services are covered?	• A physician (MD or DO) who is a psychiatrist, developmental pediatrician, or pediatric neurologist • A hospital • A state hospital maintained by the state of Washington for the care of people with a mental illness • A state-licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)

	• A state-licensed masters-level mental health clinician (e.g., licensed clinical social worker, licensed marriage and family counselor, licensed mental health counselor) • A state-licensed psychologist • Services provided by a state-approved substance use disorder treatment program or other licensed community mental health agency or behavioral health agency
What is excluded? (Premera HMO pays 0%)	• Halfway houses, quarter way houses, recovery houses, and other sober living residences • Drug or alcohol testing done for school or employment • Treatment of alcohol or drug use or abuse that doesn't meet the definition of ***Substance Use Disorder*** as stated in ***Definitions***
Related benefit information	• Some services require prior approval. See ***Prior Authorization*** for details. • See ***Emergency Services*** and ***Hospital*** for information related to emergency detoxification. • This plan will comply with federal mental health parity requirements. • See ***Virtual Care*** for information related to virtual care services.

Surgery

Surgery can be needed for many reasons. It can be done to treat a medical condition, improve bodily function, investigate a problem, relieve pain, or save your life.

Cost Overview

Important things to know:

- A typical surgery can result in multiple charges for things like the facility and professional services, you may receive separate bills for each charge.
- Many outpatient surgeries must have prior authorization before you have them. See ***Prior Authorization*** for details.

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Surgery	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient professional services	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient surgical center facility	No limit	Deductible, then 20% coinsurance	Not covered
Vasectomy	No limit	No charge	Not covered

Benefit Overview

What services are included?	• Surgical services, including injections, when performed on an inpatient or outpatient basis • Vasectomy • Anesthesia or sedation • Medically necessary postoperative care • Transfusion of blood or blood derivatives (storage is covered only when medically necessary) • Correction of functional disorders • Cochlear implants • Cornea transplantation, skin grafts, and repair of a dependent child's congenital anomaly • Medically necessary surgery to correct the cause of infertility. This doesn't include assisted reproduction techniques or sterilization reversal

	• Diagnostic colonoscopy and sigmoidoscopy services not covered under ***Preventive Care***. • Biopsies and scope insertion procedures such as endoscopies. • Reconstructive surgery that is needed because of an injury, infection or other illness. • Sexual reassignment surgery if medically necessary • Outpatient surgical center services and supplies • Surgical weight loss treatment (bariatric surgery). For a full list of services, see our medical policy by calling customer service or visit www.premera.com/sebb
Whose services are covered?	• Hospital • Ambulatory surgical centers • Surgical suite • Provider's office • Services provided by a surgeon
What is excluded? (PBC HMO pays 0%)	• Removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss • The use of an anesthesiologist for monitoring and administering general anesthesia for endoscopies, colonoscopies and sigmoidoscopies unless medically necessary when specific medical conditions and risk factors are present. (These procedures are typically done under milder forms of sedation, which would be covered.) • Cosmetic surgery
Related benefit information	• See ***Mastectomy and Breast Reconstruction*** for those covered services. • For preventive colonoscopy benefits, see ***Preventive Care.*** • For gender affirming surgery benefits, see ***Gender Affirming Care***. • For organ, bone marrow, or stem cell transplant procedure benefits, see ***Transplants.*** • See ***Hospital*** for your facility cost share amounts.

Temporomandibular Joint Disorders Care (TMJ)

Temporomandibular joint disorders (TMJ) are problems that affect the chewing muscles and joints that connect your lower jaw to your skull.

Important things to know:

- Some services covered with TMJ treatment could have additional costs, such as X-rays, hospital, and surgery.

Examples of symptoms linked with TMJ include:

- Muscle pain.
- Headaches.
- Arthritic problems.
- Clicking or locking in the jawbone.
- An abnormal range of motion or limited motion of the jawbone joint.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Office and clinic visits	No limit	$10 copay, deductible waived	Not covered
All other professional office and clinic visits (including specialists)	No limit	$40 copay, deductible waived	Not covered
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Consultations • Exams • Treatment
What's excluded? (PBC HMO pays 0%)	• A bite guard
Related benefit information	• Most TMJ services require prior authorization before you get them. See ***Prior Authorization*** for details.

Additional Information

"Medical Services" for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
- Recognized as effective, according to the professional standards of good medical practice.
- Not experimental or investigational, according to the criteria stated under ***Definitions***, or primarily for cosmetic purposes.

"Dental Services" for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
- Recognized as effective, according to the professional standards of good dental practice.
- Not experimental or investigational, according to the criteria stated under ***Definitions***, or primarily for cosmetic purposes.

Transplants

Benefits for donating or receiving an organ, bone marrow, or stem cell to be transplanted/reinfused.

Important things to know:

- Prior authorization for transplants is required. (See ***Prior Authorization*** for details.)
- You must have the transplant at an in-network provider or an Approved Transplant Center. An Approved Transplant Center is a hospital or other provider that has developed expertise in performing organ transplants or bone marrow or stem cell reinfusion.
- We have agreements with Approved Transplant Centers in Washington, and we have access to a special network of Approved Transplant Centers around the country. Whenever medically possible, we will direct you to an Approved Transplant Center that we've contracted with for transplant services.
- You must pay for all travel expenses up front and then submit a Claim Reimbursement Form for reimbursement. See ***Medical Transportation*** for benefit limits and details.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Office and clinic visits	No limit	See Professional Visits and Services	Not covered
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**Organ transplants and bone marrow/stem cell reinfusion procedures covered:** • Heart • Heart/double lung • Single/double lung • Liver • Kidney • Pancreas • Pancreas with kidney • Bone marrow (autologous and allogeneic.) • Stem cell (autologous and allogeneic) **Transplant Recipient**

	• Transplant and reinfusion related expenses, including preparation • Anti-rejection drugs administered by the transplant center during inpatient or outpatient stay **Transplant Donor** • Selection, removal, and evaluation of donor organ, bone marrow, or stem cell • Transportation of donor organ, bone marrow, or stem cells, including surgical and harvesting teams • Donor acquisition costs such as testing and typing expenses • 12-month storage costs for bone marrow and stem cells
Whose services are covered?	• Whenever medically possible, we'll help you find an Approved Transplant Center for these services. • If none of our centers or Approved Transplant Centers can provide the type of transplant you need, this benefit will cover one that meets the written approval standards we follow.
What is excluded? (PBC HMO pays 0%)	• Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers • Donor costs for an organ transplant or bone marrow stem cell reinfusion for a recipient who isn't a member • Expenses for persons other than the patient and his/her covered companion. • Non-human or mechanical organs, unless we determine they aren't experimental or investigational services • Personal care items • Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future
Related benefit information	• Travel and Lodging expenses are covered under the ***Medical Transportation*** benefit. • See ***Surgery*** benefit for coverage details for cornea transplantation, skin grafts, and the transplant of blood or blood derivatives (except for bone marrow or stem cells). • Prior authorization for transplants is required. See ***Prior Authorization*** for details.

Additional Information

The medical indications for the transplant, document effectiveness of the procedure to treat the condition, and failure of medical alternatives are all reviewed.

Urgent Care

Same-day care for medical issues that need urgent attention but are not life threatening.

Important things to know:

- Some Urgent Care Centers can be out-of-network, even if they are attached to, or part of a hospital that is in-network.
- An urgent care visit can result in multiple charges for things like the facility, shots, and tests used to diagnose your condition. You may receive separate bills for each charge.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Urgent care centers (Copay waived if admitted)	No limit	$40 copay, deductible waived	$40 copay, deductible waived

Benefit Overview

What services are included?	**Exams and treatment such as:** • Sprains. • Cuts. • Ear, nose, and throat infections. • Fever. • Urinary Tract Infections (UTI).
Related benefit information	• For tests received while at urgent care, see ***Diagnostic, X-ray, Lab, and Imaging***. • See ***Prescription Drugs*** for benefits related to medications for use after you leave the urgent care center.

Virtual Care

On-demand virtual care that connects you to providers. Benefits are provided for services for low-level conditions using virtual methods like secure chat, text, voice or video chat. Virtual care select providers can be found at www.premera.com/visitor/virtual-care or contact PBC HMO customer service for assistance.

Cost Overview

Important things to know:
You can get virtual care two ways:

- Schedule a virtual visit with an office-based provider, or
- Use a Premera-designated app to get care. Call PBC HMO for a list of covered apps.

Services must meet the following requirements:

- Covered service under this plan
- Originating site: Hospital, rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center
- If the service is provided through store and forward technology, there must be an associated office visit between the member and the referring provider
- Is Medically Necessary

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Virtual General Medical Visit	No limit	$5 copay, deductible waived	Not covered
Virtual Mental Health Visit	No limit	$10 copay, deductible waived	Not covered
Virtual Substance Use Disorder Visit	No limit	$10 copay, deductible waived	Not covered

Benefit Overview

What services are included?

- Chat
- Text
- Voice
- Audio messaging and video chat

Exclusions and Limitations

This section of your booklet lists services that are either limited or not covered by this plan.

Benefit or Service	Exclusion
Amounts over the Allowed Amount	Costs over the allowed amount as defined by this plan for a non-emergency service from an out-of-network provider.
Assisted Reproduction	Assisted reproduction technologies, including but not limited to: • Drugs to treat infertility or that are required as part of assisted reproduction procedures. • Artificial insemination or assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure. • Services to make you more fertile or for multiple births. • Reversing sterilization surgery.
Benefits from other sources	Services that are covered by other types of insurance or coverage, such as: • Motor vehicle medical or motor vehicle no-fault coverage • Any type of no-fault coverage, such as Personal Injury Protection (PIP), Medical Payment coverage or Medical Premises coverage • Any type of liability insurance, such as homeowners' coverage or commercial liability coverage • Any type of excess coverage • Boat coverage **School or athletic coverage**
Benefits that have been exhausted	Services that in excess of limitations or maximums of this plan.
Broken or missed appointments	Broken or missed appointments, including charges from providers for broken or missed appointments.
Caffeine Dependency	
Charges for records or reports	Charges from providers for supplying records or reports that aren't requested by PBC HMO for utilization review.
	•
Complications of a non-covered service	Includes follow-up services or effects of those services.
Cosmetic Services	Drugs, services, or supplies for cosmetic services that are not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This also includes drugs, services, or supplies to improve or alter the appearance of your skin or hair. This does not apply to services that are determined to be medically necessary for Gender Affirming Care.
Counseling, Education and Training	Counseling, education, or training in the absence of illness or injury, including. but not limited to: • Job help and outreach.

	• Social or fitness counseling. • Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff. • Private school or boarding school tuition. • **Community wellness or safety programs**
Court-Ordered Services	Services that you must get to avoid being tried, sentenced, or losing the right to drive when they are not medically necessary.
Custodial Care	Custodial services or supplies, that are not covered hospice care services.
Dental Care	Dental care or supplies, that are not covered under any dental benefits.
Environmental Therapy	Therapy designed to provide a changed or controlled environment.
Experimental or Investigational Services	Experimental or investigational services or supplies, including any complications or effects of such services. This does not apply to certain services that are part of an approved clinical trial.
Family Members or Volunteers	Services or supplies that give you furnish to yourself. It also doesn't cover a provider who is: • Your spouse, mother, father, child, brother, or sister. • Your mother, father, child, brother, or sister by marriage. • Your stepmother, stepfather, stepchild, stepbrother, or stepsister. • Your grandmother, grandfather, grandchild, or their spouse. • A volunteer.
Governmental Facilities	Services provided by a state or federal facility that are not emergency services or required by law or regulation.
Hair Analysis	
Hair Loss	• Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth. • Hair transplants and implants.
Illegal Acts, Illegal Services, and Terrorism	Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.
Laser Therapy	Low-level laser therapy.
Military Service and War (benefits and services covered by the military or Veteran's Affairs)	Illness or injury that is caused by or arises from: • Acts of war, such as armed invasion, no matter if war has been declared or not. • Services in the armed forces of any country, including any related civilian forces or units.
Non-Covered Services	Services or supplies directly related to any non-covered condition. • Ordered when this plan is not in effect or when the person is not covered under this plan. • Provided to someone other than the ill or injured member. • That are not listed as covered under this plan.

	• Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay • Non-treatment charges, including charges for provider time. • Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.
Non-Treatment Facilities, Institutions or Programs	• Institutional care. • Housing. • Incarceration. • Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, and juvenile detention facilities.
Orthodontia	Orthodontic services, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.
Personal comfort or convenience	• Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting • Normal living needs, such as food, clothes, housekeeping, and transport. This doesn't apply to chores done by a home health aide as prescribed in your treatment plan. • Dietary assistance, including "Meals on Wheels"
Provider's Licensing Certification	Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified providers.
Recreational, Camp and Activity Programs	Recreational, camp and activity-based programs. These programs are not medically necessary and include: • Gym, swim and other sports programs, camps, and training. • Creative art, play and sensory movement and dance therapy. • Recreational programs and camps. • Boot camp programs, outward bound programs and tall-ship programs. • Equine programs and other animal-assisted programs and camps. • Exercise and maintenance-level programs. • Hiking, and other adventure programs and camps.
Serious Adverse Events and Never Events	Serious Adverse Events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge. Never Events are events that should never occur, such as a surgery on the wrong patient, surgery on the wrong body part or a wrong surgery. Members and this plan are not responsible for payment of services provided by providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. Providers may not bill members for these services and members are held harmless. Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events

	by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.
Services or Supplies Not Medically Necessary	Services or supplies that are not medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care or stays.
Sexual Dysfunction	Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical, or psychological treatment of impotence or hypoactive sexual desire disorder, including drugs, medications, or penile or other implants.
Vision Therapy	Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics, treatment or surgeries to improve the refractive character of the cornea, or results of these treatments.
Voluntary Support Groups	Patient support, consumer, or affinity groups such as diabetic support groups or Alcoholics Anonymous.
Work-Related Illness or Injury	Any illness or injury for which you get benefits under: • Separate coverage for illness or injury on the job • Workers compensation laws **Any other law that would repay you for an illness or injury you get on the job**

Other Coverage

COORDINATING BENEFITS WITH OTHER HEALTH PLANS

What is Coordination of Benefits? If you have other health plan coverage (for example through your spouse's employer), PBC HMO works with the other plan so that both plans may share a part of the costs.

All benefits of this plan are subject to coordination of benefits. However, benefits provided under this plan for allowable dental expenses will be coordinated separately from allowable medical expenses.

If you have other coverage besides this plan, we recommend that you send your claims to the primary plan first. This will help the proper coordinated benefits be quickly determined and paid.

Definitions Applicable to Coordination of Benefits (COB)

Term	Definition
Allowable Expense	Allowable expense is a healthcare expense, including deductibles, coinsurance and copays, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that is not covered by any of your plans is not an allowable expense. The allowable expense for the secondary plan is the amount it allows for the service or supply in the absence of other coverage that is primary. This is true regardless of what method the secondary plan uses to set allowable expenses. The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.
Custodial Parent	The parent awarded custody by a court decree. In the absence of a court decree, the parent with whom the child lives with for more than half of the calendar year, excluding any temporary visitation.
Dental Plan & Medical Plan	All of the following health and dental care coverages, even if they don't have their own coordination provisions. **Dental and Medical** • Group, individual, or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractor, and health maintenance organizations. • Labor-management trusteed plans, labor organization plans, employer organization plans or benefit organization plans. • Government programs that provide benefits for their own civilian employees or their dependents. **Medical Only** • Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation. • Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease.

PRIMARY AND SECONDARY RULES

Certain governmental plans, like Medicaid, are always secondary by law. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

A plan that doesn't have a coordination of benefits provision that complies with this plan's rules is primary to this plan unless the rules of both plans make this plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan.

The first of the rules below to apply decides which plan is primary. If you have more than one secondary plan, the rules below also decide the order of the secondary plans to each other.

Non-Dependent or Dependent	The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.
Dependent Children	Unless a court decree states otherwise, the rules below apply: • **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary. **When the parents are divorced, separated, or not living together, whether or not they were ever married:** • If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. If the parent who is responsible has no health coverage for the dependent, but that parent's spouse does, that spouse's plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree. **If a court decree:** • Assigns one parent primary financial responsibility for the child, the plan of the parent with financial responsibility is primary. • Makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary. • Requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary. **If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:** • The plan covering the custodial parent, first • The plan covering the spouse of the custodial parent, second • The plan covering the non-custodial parent, third • The plan covering the spouse of the non-custodial parent, last • If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.
Retired or Laid-off Employee	The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

TRICARE	If you are a member of the U.S. military (active or retired) or you have dependents enrolled in the TRICARE program, this plan is the primary plan and TRICARE would be secondary, when required by federal law.
Continuation Coverage	If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that is not through COBRA or other continuation law. **Note**: The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.
Length of Coverage	The plan that covered you longer is primary to the plan that didn't cover you as long. If none of the rules above apply, the plans must share the allowable expenses equally.

RIGHT OF RECOVERY/FACILITY OF PAYMENT

The plan has the right to recover any payments that are greater than those required by the coordination of benefits provisions from one or more of the following:

- The persons the plan paid or for whom the plan has paid
- Providers of service
- Insurance companies
- Service plans or other organizations

If a payment that should have been made under this plan was made by another plan, the plan also has the right to pay directly to another plan any amount that the plan should have paid. Such payment will be considered a benefit under this plan and will meet the plan's obligations to the extent of that payment. This plan has the right to appoint a third party to act on its behalf in recovery efforts.

THIRD PARTY RECOVERY

If you become ill or are injured by the actions of a third party, your medical care should be paid by that third party. For example, if you are hurt in a car crash, the other driver or their insurance company may be required under law to pay for your medical care.

This plan doesn't pay for claims for which a third party is responsible. However, the plan may agree to advance benefits for your injury with the understanding that it will be repaid from any recovery received from the third party. By accepting plan benefits for the injury, you agree to comply with the terms and conditions of this section.

In addition, the plan maintains a right of subrogation, meaning the right of the plan to be substituted in place of the member who received benefits with respect to any lawful claim, demand, or right of action against any third party that may be liable for the injury, illness or medical condition that resulted in payment of plan benefits. The third party may not be the actual person who caused the injury and may include an insurer to which premiums have been paid.

The plan administrator has discretion to interpret and to apply the terms of this section. It has delegated such discretion to Premera Blue Cross HMO and its affiliate to the extent we need in order to administer this section.

Note: For this section, a third party doesn't include other health care plans that cover you.

DEFINITIONS

The following definitions apply to this section:

Term	Definition
Injury	An injury or illness that a third party is or may be liable for.
Recovery	All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgement, award, or settlement. It doesn't matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amount put into a trust or constructive trust set up by or for you or your family, beneficiaries, or estate as a result of your injury.
Reimbursement Amount	The amount of benefits paid by the plan for your injury that you must pay back to the plan out of any recovery per the terms of this section.
Responsible Third Party	A third party that is or may be responsible under the law ("liable") to pay you back for your injury.
Third Party	A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers' compensation coverage. The third party may not be the actual party who caused the injury and may include an insurer.
You	In this section, "you" includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

Benefits From Other Sources

Benefits are not available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage, or Medical Premises coverage
- Boat coverage
- School or athletic coverage
- Any type of liability insurance, such as homeowners' coverage or commercial liability coverage
- Any type of excess coverage

Work-Related Illness or Injury

This plan doesn't cover any illness, condition, or injury, for which you get benefits under:

- Separate coverage for illness or injury on the job
- Workers' compensation laws
- Any other law that would pay you for an illness or injury you get on the job

This exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers'

compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.

If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits. The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer, or your estate. The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.

The plan's right to reimbursement first and in full shall apply even if:

- The recovery is not enough to make you whole for your injury
- The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
- The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
- The member is a minor, disabled person, or isn't able to understand or make decisions.
- The member didn't make a claim for medical expenses as part of any claim or demand
  - Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
  - In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must cooperate with the plan as it pursues its claim.
  - The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
  - You cannot assign any rights or causes of action that you might have against a third-party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

You must notify Premera Blue Cross HMO of the injury immediately and no later than 30 days of any claim for the injury.

You must notify the third parties of the plan's rights under this provision

You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.

If you hire a lawyer, you must tell Premera Blue Cross HMO right away and provide the contact information.

Neither the plan nor Premera Blue Cross HMO shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify, and hold the plan and Premera Blue Cross HMO harmless from any claims from your lawyer for lawyer's fees or costs.

You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

Claims for your injury will not be paid until Premera Blue Cross HMO receives a completed copy of the Incident Questionnaire when one was sent.

You must tell Premera Blue Cross HMO if you have received recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.

You must notify the plan at least 14 days prior to any settlement, trial, or other material hearing concerning the suit or claim.

If any of the requirements above are not met, the plan shall:

- Deny or delay claims related to your injury
- Recoup directly from you all benefits the plan has provided for your injury
- Deduct the benefits owed from any future claims

Reimbursement and Subrogation Procedures

If you receive a recovery, you or your lawyer shall hold the recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the plan's reimbursement rights have been determined you shall make immediate payment to the plan out of the recovery proceeds.
If you or your lawyer don't promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount.

Such action shall include, but not be limited to one or both of the following:

- Initiating an action against you and/or your lawyer to compel compliance with this section
- Withholding plan benefits payable to you or your family until you and your lawyer complies or until the reimbursement amount has been fully paid to the plan.

How Do I File a Claim?

Many providers will submit their bills to PBC HMO directly. However, if you need to submit a claim, follow these simple steps:

Medical Claims

Step 1. Get the form	• Complete the Claim Reimbursement Form, you can find it on premera.com/sebb or call customer service to request a copy. • A separate form is needed for each patient and each provider.

**Step 2.
Collect required documents**
	If requesting reimbursement for medical or dental care, include:
	• Proof of payment (if applicable).
	• An itemized bill that includes:
	  • Name of the patient.
	  • Date of service.
	  • Name, address, and IRS tax ID of the provider.
	  • Diagnosis code (ICD-10) – You can get this from your provider.
	  • Procedure code (CPT-4, HCPCS, ADA, or B-04) – You can get this from your provider.
	  • Itemized charge for each service received.

	• Member ID numbers for both subscriber and the group. If you're also covered by another health insurance (including Medicare) and it's your primary, you must attach a copy of the explanation of benefits from the other health plan.
Step 3. Send in my claim	To help process your claim, the form must be fully completed, signed, and returned with all required documents. Send your documents one of two ways: • **Email through your Secure Inbox** Sign into your account at premera.com/sebb and select Secure Inbox. Scan and send the completed form and any required documents back to us as a secure email attachment. • **Mail to** Premera Blue Cross HMO PO Box 91059 Seattle, WA 98111-9159 **Note:** Any highlights or modifications to your bill may delay processing your claim.

Prescription Drug Claims

In-Network Pharmacies	**For retail pharmacy purchases:** • Show your Premera Blue Cross HMO member ID card to the pharmacist and they will bill us directly. • If you don't show your member ID card, you'll have to pay the full cost of the prescription and submit the claim yourself. **For mail-order pharmacy purchases:** • Follow the instructions on the order form and submit it to the address on the form. Please allow up to 14 days for delivery. If you need an in-network mail-order pharmacy order form, contact PBC HMO customer service)
Coordination of Prescription Claims	• Complete a Prescription Drug Claim Form and attach any receipts. • Send the form with all required documents to the address on the form. If you need a Prescription Drug Claim Form contact PBC HMO customer service
Where do I send my claim?	**Questions?** Contact our pharmacy benefit manager, Express Scripts at: • 800-391-9701 • Or visit express-scripts.com **Mail your prescription drug claims to:** Express Scripts ATTN: Commercial Claims PO Box 14711 Lexington, KY 40512-4711

Timely Filing

We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses.
- Or within 365 days of the date the expenses were incurred for any other services.
- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

The plan won't provide benefits for claims we receive after the later of these 2 dates except when required by law.

Special Notice About Claims Procedure

We process claims in the order received and will make every effort to process your claims as quickly as possible.

Within 30 days of receiving a claim, we'll send you a written notice letting you know if this plan will cover all or part of the claim. We can extend the time limit up to 15 days if more time is needed due to matters beyond our control. If we do need more time, we'll let you know before the 30-day time limit ends.
If more information is needed to help decide your claim, we'll reach out to you or your provider. You or your provider will have at least 45 days to send us the information. The time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information needed, we have 15 days to give you our decision.
If all or part of your claim was denied, our written notice(s) will include:

- The reason(s) for the denial and a reference to the provisions of this plan on which it's based.
- A description of any additional information needed to reconsider the claim and why it's needed.
- Any clinical reason for the denial, if applicable, in a letter stating these reasons.
- A statement that you have the right to appeal our decision.
- A description of the plan's complaint and appeal process.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a provider, lawyer, friend or a relative. You must notify us in writing and give the name, address, and telephone number where your appointee can be reached.
If all or part of your claim is denied you may send us a complaint or appeal as outlined under ***Complaints and Appeals***.
If all or part of a claim or an appeal is denied, ignored, or not processed within the time shown in this plan, you may file suit in a state or federal court.

Additional Information

Any notice we're required to send to the Group or subscriber will be considered delivered if it's mailed or emailed to the most recent mailing or email address appearing on our records.

We'll use the date of postmark or email date when determining the date of our notification. If you're required to send us a notice, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

If you only had to pay a copay to your provider for a covered service, that is not considered a claim for benefits. To get a paper copy of an explanation of benefits call customer service. Or you can visit premera.com/sebb for secure online access to your claims.

NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIMS

At our option and in accordance with federal and Washington state law, we may pay the benefits of this plan to the eligible member, provider, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge our obligation to the extent of the amount paid so that we will not be liable to anyone aggrieved by our choice of payee.

’Complaints and Appeals

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with PBC HMO.

WHAT IS A COMPLAINT?

Other than denial of payment for medical services or nonprovision of medical services, a complaint is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with PBC HMO.

How to file a complaint

Call customer service

Send a fax to 425-918-5592

Send the details in writing to:
Premera Blue Cross HMO
PO Box 91102
Seattle, WA 98111-9202

For complaints received in writing, we will send a written response within 30 days.

WHAT IS AN APPEAL?

An appeal is a request to review a specific decision or an adverse benefit determination PBC HMO has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

WHAT YOU CAN APPEAL

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits
	Denied	Coverage of your service, supply, device, or prescription was denied or partially denied. This includes prior authorization denials. It also includes denials of drugs not on the plan's formulary drug list. See ***Prescription Drugs*** for details.

APPEALS LEVELS

You have the right to two levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. PBC HMO will review your appeal	180 days from the date you were notified of our decision
External	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if PBC HMO hasn't made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	Four months from the date you were notified of our Level 1 appeal decision. OR Four months from the date the response to your Level 1 appeal was due if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. Get the form	• Complete the **Member Appeal Form**, you can find it on premera.com/sebb or call customer service to request a copy. If you need help filing out an appeal, or would like a copy of the appeals process, call customer service
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with Authorization, you can find it on premera.com/sebb. We can't release your information without this form. If you'd like to review the information used for your appeal, call customer service and the information will be sent as soon as possible.

Step 3. Send in my appeal	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross HMO Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 **Fax to** 425-918-5592

If you would like to review the information used for your appeal, send us a request in writing to:

Premera Blue Cross HMO
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111-9202
Fax to 425-918-5592

Appeal Response Time Limits

We'll review your appeal and send a decision in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, PBC HMO representatives who have not reviewed the case before will review and make a decision. Medical review denials will be reviewed by a medical specialist.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decisions, and follow up in writing
Pre-service appeals (a decision made by us before you receive services)	Within 14 days
Appeals of experimental and investigative denials	Within 20 days
All other appeals	14-30 days
External appeals	• Urgent appeals within 72 hours • Other IRO appeals within 15 days after the IRO gets the information or 20 days from the date the IRO gets your request

IF WE NEED MORE TIME

Except for urgent appeals, we can extend the time limits. We will notify you, if for good cause, more time is needed. An extension cannot delay the decision beyond 30 days without your informed written consent.

WHAT IF YOU HAVE ONGOING CARE?

Ongoing care is continuous treatment you're currently receiving, such as residential care, care for a chronic condition, inpatient care, and rehabilitation.
If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, the plan will continue to cover your care during the appeal period. This continued coverage during the appeal period doesn't mean that the care is approved. If your decision is upheld, you must repay all amounts the plan paid for ongoing care during the appeal review.

WHAT IF IT'S URGENT?

If your condition is urgent, you will get your response sooner. Urgent appeals are only available for services you are currently receiving or haven't yet received.

Examples of urgent situations are:

- Your life or health is in serious danger, or delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professional or your treating physician

- You're requesting coverage for inpatient or emergency services that you're currently receiving

  If your situation is urgent, you may ask for an expedited external appeal at the same time you request an expedited internal appeal.

HOW TO ASK FOR AN EXTERNAL REVIEW

External reviews will be done by an Independent Review Organization (IRO).

Step 1. Get the form	**We'll tell you about your right to an external review with the written decision of your internal appeal.** • Complete the Independent Review Organization (IRO) Request form, you can find it on **premera.com/sebb** or call customer service to request a copy.
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your external review This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). If you have additional information on your appeal, you may send it to the IRO.
Step 3. Send in my external review request	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross HMO Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202

External appeals are available for decisions related to PBC HMO's compliance with protections against balance billing in accordance with federal and state law.

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and PBC HMO immediately after a decision has been made. PBC HMO will accept the IRO decision on behalf of the plan.

If the IRO:

- Reverses our decision, we will apply their decision quickly
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about a denial of a claim or your appeal rights, you may call customer service at the number listed on your PBC HMO ID card. Contact Washington Consumer Assistance Program at any time during this process if you have any concerns or need help filing an appeal.

Washington Consumer Assistance Program
5000 Capitol Blvd.
Tumwater, WA 98501

800-562-6900

E-mail: cap@oic.wa.gov

You can also contact the Employee Benefits Security Administration of the U.S. Department of Labor at 866-444-EBSA (3272).

Medical Plan Eligibility and Enrollment

In these sections, “health plan” is used to refer to a plan offering medical, vision, dental, or any combination of these coverages, developed by the School Employees Benefits Board (SEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility for Subscribers and Dependents

School Employee Eligibility

The school employee’s SEBB organization will inform the school employee in writing whether or not they are eligible for SEBB benefits upon employment and whenever their eligibility status changes. The written notice will include information about the school employee’s right to appeal eligibility and enrollment decisions.

A school employee of an employer group (such as an employee organization representing school employees or a tribal school) that contracts with HCA for SEBB benefits should contact their payroll or benefits office for eligibility criteria.

School employees have the right to appeal eligibility and enrollment decisions. Information about appeals can be found under “Appeal rights.”

Continuation Coverage Eligibility

The SEBB Program determines whether subscribers are eligible for SEBB Continuation Coverage (COBRA or Unpaid Leave) upon receipt of their election to enroll in *SEBB Continuation Coverage (COBRA or Unpaid Leave)*. If the subscriber requests to enroll and is not eligible, the SEBB Program will notify them of their right to appeal. Information about appeals can be found under “Appeal rights.”

School board member eligibility

The SEBB Program determines whether a school board member is eligible to self-pay coverage upon receipt of their election to enroll. If a school board member requests to enroll and is not eligible, the SEBB Program will notify them of their right to appeal. Information about appeals can be found under “Appeal rights.”

Dependent Eligibility

The following are eligible dependents:

- Legal spouse
- State-registered domestic partner and substantially equivalent legal unions from jurisdictions as defined in Washington state statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in “Children of any age with a developmental or physical disability.” Children are defined as the subscriber’s:
    - **Children based on establishment of a parent-child relationship,** as described in Washington state statutes, except when parental rights have been terminated.
    - **Children of the subscriber’s spouse,** based on the spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
    - **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
    - **Children of the subscriber’s state-registered domestic partner,** based on the state-registered domestic partner’s establishment of a parent-child relationship, except when parental rights have been terminated. The child’s relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber’s legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.

- **Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage.**
- **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.** The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.
- **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:
  - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
  - The subscriber must notify the SEBB Program in writing when the child is no longer eligible under this subsection.
  - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
  - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.
  - The SEBB Program, with input from the medical plan, will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

Enrollment for Subscribers and Dependents

For all Subscribers and Dependents

- To enroll at any time other than during the initial enrollment period, see "Making changes."
- Any dependents enrolled in medical coverage will be enrolled in the same medical plan as the subscriber.

School Employee Enrollment

A school employee must use Benefits 24/7, the SEBB Program's online enrollment system, or submit a *School Employee Enrollment/Change* form or *School Employee Enrollment/Change form for Medical Only Groups*, and any supporting documents to their SEBB organization or employer group when they become newly eligible or regain eligibility for SEBB benefits. The online enrollment must be completed or the form must be received no later than 31 days after the date the school employee becomes eligible or regains eligibility.

If the school employee does not enroll online or return the form by the deadline, the school employee will be enrolled in Uniform Medical Plan Achieve 1 and a tobacco use premium surcharge will be incurred. Consequently, dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment for enrolling a dependent.

Waiving Medical Enrollment

An eligible school employee may waive enrollment in SEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B. They may not waive enrollment in SEBB medical if they are enrolled in Public Employees Benefits Board (PEBB) retiree insurance coverage. The PEBB Program will automatically defer their enrollment or automatically disenroll them from PEBB retiree insurance coverage when they become eligible for the employer contribution toward SEBB benefits.

A school employee may waive their enrollment in SEBB medical to enroll in PEBB medical only if they are enrolled in PEBB dental and PEBB vision. A school employee who waives enrollment in SEBB medical to enroll in PEBB medical also waives enrollment in SEBB dental and SEBB vision. A school employee may not waive SEBB

medical, SEBB dental, and SEBB vision to enroll in PEBB medical with a PEBB participating employer group that offers only medical coverage.

If a school employee waives enrollment in SEBB medical, the school employee cannot enroll eligible dependents. For information on when an eligible school employee may waive SEBB medical after their initial enrollment period, or to enroll after having waived, see “Making changes.”

Continuation Coverage Enrollment

A subscriber enrolling in SEBB Continuation Coverage (COBRA or Unpaid Leave) may enroll by using benefits 24/7 or by submitting the *SEBB Continuation Coverage (COBRA/Unpaid Leave) Election/Change* form and any supporting documents to the SEBB Program. The SEBB Program must receive the election form no later than 60 days from the date the enrollee’s SEBB health plan coverage ended or from the postmark date on the *SEBB Continuation Coverage Election Notice* sent by the SEBB Program, whichever is later.

Premiums and applicable premium surcharges associated with continuing SEBB medical must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see “Options for continuing SEBB medical coverage” and the *SEBB Continuation Coverage Election Notice* sent by the SEBB Program.

School board member enrollment

A school board member enrolling in SEBB health plan coverage is required to enroll in SEBB medical.

An elected or appointed school board member may enroll and self-pay premiums by submitting the *SEBB School Board Member Election/Change* form and any supporting documents to the SEBB Program. The SEBB Program must receive the form as follows:

- **Upon being elected or appointed:** No later than 60 days from the beginning of their elected or appointed term.
- **During the annual open enrollment:** No later than the last day of the annual open enrollment period.
- **Following the loss of other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA):** No later than 60 days after the date of the loss of other coverage. Proof of loss of other coverage will be required.

Premiums and applicable premium surcharges associated with continuing SEBB medical must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the 60-day election period ends or the last day of the annual open enrollment period as described above.

A school board member may renew their participation at the start of each subsequent term as a school board member. If a school board member is reelected for a new term consecutive from their previous term, they will not be required to make new elections.

Dependent Enrollment

To enroll an eligible dependent, the subscriber must include the dependent’s information online using SEBB My Account or benefits 24/7 or on the applicable enrollment form and provide the required document(s) as proof of the dependent’s eligibility. The dependent will not be enrolled in SEBB health plan coverage if the SEBB Program, the SEBB organization, or the employer group is unable to verify their eligibility within the SEBB Program enrollment timelines.

National Medical Support Notice (NMSN)

When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child, the following provisions apply:

The subscriber may enroll their dependent child and request changes to their health plan coverage as described under “Changes to health plan coverage or enrollment are allowed as directed by the NMSN” below.

- **A school employee** must use the SEBB My Account online enrollment system or Benefits 24/7 (once available) or submit the required form(s) to their SEBB organization or employer group.

- **Any other subscriber** must use Benefits 24/7 (once available) or submit the required form(s) to the SEBB Program.

If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the SEBB organization, the employer group, or the SEBB Program may make enrollment or health plan coverage changes according to "Changes to health plan coverage or enrollment are allowed as directed by the NMSN" below, upon request of:

- The child's other parent.
- A child support enforcement program.

Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

a) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN.

b) A school employee who has waived SEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent.

c) The subscriber's selected health plans will be changed if directed by the NMSN.

d) If the dependent is already enrolled under another SEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.

e) If the dependent is enrolled in both SEBB medical and Public Employees Benefits Board (PEBB) medical as a dependent and there is an NMSN in place, enrollment will be in accordance with the NMSN.

f) If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

Changes to health plan coverage or enrollment as described above in (a) through (c) will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day.

A dependent will be removed from the subscriber's health plan coverage, as described above in (d), the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in the subscriber's SEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's SEBB health plan coverage prospectively.

Dual Enrollment

A subscriber and their dependents may each be enrolled in only one SEBB medical plan.

A school employee or their dependent who is eligible to enroll in both the SEBB Program and the Public Employees Benefits Board (PEBB) Program is limited to a single enrollment in either the SEBB or PEBB Program.

For example:

- A child who is an eligible dependent under two parents enrolled in SEBB Program benefits may be enrolled as a dependent under both parents but is limited to a single enrollment in SEBB medical.
- A child who is an eligible dependent of a school employee in the SEBB Program and an employee in the PEBB Program may only be enrolled as a dependent under one parent in either the SEBB or PEBB Program.

Medicare Eligibility and Enrollment

School Employee and Dependent

If a school employee or their dependent becomes eligible for Medicare, they should contact the Social Security Administration to ask about the advantages of immediate or deferred Medicare enrollment.

A school employee or their dependent are deemed eligible for Medicare when they have the option to receive Medicare Part A benefits. If a school employee or their dependent chooses to enroll in Medicare Part A, Medicare regulations and guidelines will determine whether Medicare is the primary or secondary payer.

A school employee or their dependent who is enrolled in Medicare may remain enrolled in SEBB medical coverage. However, a school employee may choose to waive their SEBB medical if they are enrolled in Medicare Part A and Part B or remove their dependent from their SEBB medical coverage and choose Medicare as their primary insurer. If a school employee does so, neither the school employee nor their dependent can enroll in SEBB medical except during the annual open enrollment or when a specific life event creates a special open enrollment.

In most situations, a school employee and their dependent can defer Medicare Part B enrollment without a penalty while enrolled in SEBB medical coverage. When the school employee terminates employment, the school employee and the dependent can enroll in Medicare Part B during a Special Enrollment Period. If Medicare eligibility is due to a disability, the school employee or their dependent must contact the Social Security Administration about deferring enrollment in Medicare Part B.

Upon retirement, Medicare will become the primary insurance payer, and the PEBB medical plan will become secondary. See “PEBB retiree insurance coverage.”

Continuation Coverage Subscriber, a School Board Member, or their and Dependent

If a continuation coverage subscriber, a school board member or their dependent becomes eligible for Medicare when they are turning age 65 but not getting Social Security benefits, federal regulations allow a seven-month initial enrollment period to enroll in Medicare. If they do not enroll within three months before the month they turn age 65, enrollment in Medicare may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first eligible, a late enrollment penalty may apply.

A SEBB Continuation Coverage (COBRA) subscriber must notify the SEBB Program in writing within 30 days if, after electing SEBB Continuation Coverage (COBRA), a subscriber or their dependent becomes eligible for Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. If a subscriber or their dependent enrolls in SEBB Continuation Coverage (COBRA) and then becomes eligible for Medicare, their enrollment in SEBB Continuation Coverage (COBRA) will be terminated at the end of the month in which they become eligible for Medicare due to turning age 65 or older or when enrolled in Medicare due to a disability. This may cause the SEBB Continuation Coverage (COBRA) to be terminated early, before the subscriber has used all the months they would otherwise be entitled to. A subscriber or their dependents who are already enrolled in Medicare when they enroll in SEBB Continuation Coverage (COBRA) will not have their coverage terminated early.

When Medical Coverage Begins

School Employees and Dependents

For a newly eligible school employee and their eligible dependents**,** medical coverage begins the first day of the month following the date the school employee becomes eligible.

Exceptions:

- Medical coverage begins on the school employee’s first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB organization.
- When a school employee establishes eligibility toward SEBB benefits at any time in the month of August, medical coverage begins on September 1 only if the school employee is also determined to be eligible for the school year that begins on September 1.

For a school employee regaining eligibility, including following a period of leave as described in SEBB Program rules, and their eligible dependents, medical coverage begins the first day of the month following the school employee’s return to work if the school employee is anticipated to be eligible for the employer contribution.

Note: When a school employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they

return from active duty. Medical coverage begins the first day of the month in which the school employee returns from active duty.

Continuation Coverage Subscriber and Dependents

For a continuation coverage subscriber and their eligible dependents enrolling when newly eligible due to a qualifying event, medical coverage begins the first day of the month following the day they lost eligibility for SEBB medical plan coverage.

School board members and dependents

When an elected or appointed school board member requests to enroll:

Upon being elected or appointed, medical coverage for the school board member and their eligible dependents begins the first day of the month following the day the SEBB Program receives the required form.

During the annual open enrollment, medical coverage for the school board member and their eligible dependents begins January 1 of the following year.

Following the loss of other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA), medical coverage for the school board member and their eligible dependents begins the first day of the month following the later of the date of loss of other coverage or the date the SEBB Program receives the required form.

All Subscribers and Dependents

For a subscriber or their eligible dependents enrolling during the SEBB Program's annual open enrollment, medical coverage begins January 1 of the following year.

For a subscriber or their eligible dependents enrolling during a special open enrollment, medical coverage begins the first day of the month following the event date or the date the online enrollment election using SEBB My Account or benefits 24/7 (once available), or the required form is received. If that day is the first of the month, medical coverage begins on that day.

If the special open enrollment is due to the **birth or adoption of a child**, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage will begin as follows:

- **For a school employee,** medical coverage will begin the first day of the month in which the event occurs.
- **For a newly born child,** medical coverage will begin the date of birth.
- **For a newly adopted child,** medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.
- **For a spouse or state-registered domestic partner** of a subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of **an extended dependent or a dependent child with a disability**, medical coverage will begin the first day of the month following the event date or eligibility certification, whichever is later.

Making Changes

Removing a dependent who is no longer eligible

A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child as described under "Dependent eligibility." The notice must be received within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

- **A school employee** must provide notice online using SEBB My Account or Benefits 24/7 (once available), or by submitting a written request to their SEBB organization or employer group.
- **Any other subscriber** must provide notice online using Benefits 24/7 (once available) or by submitting a written request to the SEBB Program.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue SEBB medical coverage under one of the continuation coverage options described in “Options for continuing SEBB medical coverage.”
- The subscriber may be billed for claims paid by the medical plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.
- The subscriber may be responsible for premiums paid by the state for the dependent’s medical plan coverage after the dependent lost eligibility.

Voluntary termination for continuation coverage subscribers or school board members

A continuation coverage subscriber or school board members may voluntarily terminate enrollment in a medical plan at any time by submitting a request online using Benefits 24/7 (once available) or in writing to the SEBB Program. Enrollment in the medical plan will be terminated the last day of the month in which the request was received online or by the SEBB Program or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

Note: A school board member must be enrolled in all SEBB health plan coverage, including SEBB medical, SEBB dental, and SEBB vision. A school board member who voluntarily terminates enrollment in a medical plan also terminates all other health plan enrollment. If a school board member requests to voluntarily terminate their enrollment prior to the end of their elected term, they are no longer eligible to participate in SEBB health plan coverage for the remainder of their elected term.

Making changes during annual open enrollment and special open enrollment

A subscriber may make certain changes to their enrollment during the annual open enrollment or when a specific life event creates a special open enrollment period.

Annual Open Enrollment Changes

A school employee may make the following changes to their enrollment during the SEBB Program’s annual open enrollment period:

- Change their medical plan
- Waive their medical plan enrollment
- Enroll after waiving medical plan enrollment
- Enroll or remove eligible dependents

A school employee must submit the election change online using SEBB My Account or Benefits 24/7 (once available) or submit the required *School Employee Enrollment/Change* form and any supporting documents to their SEBB organization or employer group. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period.

Any other subscriber may make the following changes to their enrollment during the SEBB Program’s annual open enrollment period:

- Enroll in or terminate enrollment in a medical plan
- Change their medical plan
- Enroll or remove eligible dependents

They must submit the election change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage (COBRA/Unpaid Leave) Election/Change* or *SEBB School Board Member Election/Change* form (as appropriate) and any supporting documents to the SEBB Program. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period.

The change will be effective January 1 of the following year, except when a subscriber chooses to terminate enrollment or remove an eligible dependent, then the change will be effective on December 31.

Special Open Enrollment Changes

A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

A special open enrollment event must be other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits.

A special open enrollment may allow a subscriber to make the following changes:

- Enroll in or change their medical plan
- Waive their medical plan enrollment
- Enroll after waiving medical plan enrollment
- Enroll or remove eligible dependents

To request a special open enrollment:

- **A school employee** must make the change online using SEBB My Account or Benefits 24/7 (once available) or submit the required *School Employee Enrollment/Change form* and any supporting documents to their SEBB organization or employer group.
- **Any other subscriber** must make the change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage (COBRA/Unpaid Leave) Election/Change or SEBB School Board Member Election/Change* form (as appropriate) and any supporting documents to the SEBB Program.

The change must be completed online, or the forms must be received no later than 60 days after the event that creates the special open enrollment. In many instances, the date the change is received online or the date the form is received affects the effective date of the enrollment or change in enrollment. Submitting the requested change sooner may avoid a delay in the enrollment or change. In addition, the SEBB Program, the SEBB organization, or the employer group will require the subscriber to provide proof of a dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception: If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should complete the request online or notify their SEBB organization, their employer group, or the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required forms must be received, no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan during a special open enrollment if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber has a change in employment location that affects medical plan availability. If the subscriber changes employment locations and their current medical plan is no longer available, the subscriber must select a new medical plan. If the subscriber does not elect a new medical plan as required, they will be enrolled in a SEBB medical plan designated by the director of HCA or their designee. If the subscriber

has one or more new medical plans available, the subscriber may select to enroll in a newly available plan.

- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan. If the subscriber does not elect a new medical plan as required, they will be enrolled in a SEBB medical plan designated by the director of HCA or their designee.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependent's enrollment in Medicare, the subscriber must select a new medical plan.
- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber or dependent's physician stops participation with the subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but not limit its consideration to the following:
    - Active cancer treatment, such as chemotherapy or radiation therapy
    - Treatment following a recent organ transplant
    - A scheduled surgery
    - Recent major surgery still within the postoperative period
    - Treatment for a high-risk pregnancy
- Subscriber or their dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.
- The SEBB Program determines that there has been a substantial decrease in the providers available under a SEBB medical plan.
- The SEBB Program determines that there has been a substantial increase in the school employee's premiums when the school employee moves to another SEBB organization or employer group.

Note: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the SEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the SEBB Program determines that a continuity of care issue exists or there has been a substantial decrease in the providers available under the plan.

Special open enrollments events that allow adding or removing a dependent

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
    - Marriage or registering a state-registered domestic partnership.
    - Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.

    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment.
- Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.
- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.
- Subscriber or their dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.

Special open enrollment events that allow waiving medical enrollment and enrolling after waiving

A school employee may waive SEBB medical during a special open enrollment if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B. A school employee may not waive enrollment in SEBB medical if they are enrolled in PEBB retiree insurance coverage. Their enrollment in PEBB retiree insurance coverage will be automatically deferred or automatically disenrolled by the PEBB Program.

Any of the following events may create a special open enrollment:

- School employee gains a new dependent due to:
    - Marriage or registering a state-registered domestic partnership.
    - Birth, adoption, or when the school employee has assumed a legal obligation for total or partial support in anticipation of adoption.
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- School employee or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA.
- School employee has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group medical.
- School employee's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group medical. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- School employee or their dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment.
- School employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and the change in residence resulted in the dependent losing their health insurance.

- A court order requires the school employee or any other individual to provide a health plan for an eligible dependent of the school employee (a former spouse or former state-registered domestic partner is not an eligible dependent).
- School employee or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the school employee or their dependent loses eligibility for coverage under Medicaid or CHIP. **Note:** A school employee may only return from having waived SEBB medical for the events described in this paragraph. A school employee may not waive their SEBB medical for the events described in this paragraph.
- School employee or their dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.
- School employee or their dependent becomes eligible and enrolls in a TRICARE plan or loses eligibility for a TRICARE plan.
- School employee becomes eligible and enrolls in Medicare or loses eligibility for Medicare.

When Medical Coverage Ends

Termination dates

Medical coverage ends on the following dates:

- On the last day of the month when any enrollee ceases to be eligible. For a school board member this includes when their elected or appointed term ends.
- On the date a medical plan terminates due to a change in contracted service area or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another SEBB medical plan.
- **For a school employee** and their dependents when the employment is terminated, medical coverage ends when:
    - The school employee resigns. If this is the case, medical coverage ends on the last day of the month in which a school employee's resignation is effective; or
    - The SEBB organization or the employer group terminates the employment relationship. If this is the case, medical coverage ends on the last day of the month in which the employer-initiated termination is effective.

Note: If the SEBB organization or the employer group deducted the school employee's portion of the premium for SEBB insurance coverage after the school employee was no longer eligible for the employer contribution, medical coverage ends the last day of the month for which school employee premiums were deducted.

- **For a continuation coverage subscriber** or a school board member who submits a request to terminate medical coverage, enrollment in medical coverage will be terminated the last day of the month in which the request was received online using Benefits 24/7 (once available) or by the SEBB Program or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical coverage will be terminated on the last day of the previous month.

A subscriber will be responsible for payment of any services received after the date medical coverage ends as described above.

Final Premium Payments

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their medical plan before the end of the month.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, the account will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance and applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, the subscriber's medical coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid. When a subscriber is terminated for non-payment of premiums and applicable premium surcharges, they may not enroll again unless they regain eligibility for SEBB benefits.

If An Enrollee is Hospitalized

An enrollee who is receiving covered services in a hospital on the date medical coverage ends will continue to be eligible for covered services while an inpatient for the condition which the enrollee was hospitalized, until one of the following events occur:

- According to this plan's clinical criteria, it is no longer medically necessary for the enrollee to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The enrollee becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The enrollee becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the enrollee is eligible for SEBB Continuation Coverage as described in "Options for continuing SEBB medical coverage."

Options for Continuing SEBB Medical Coverage

When medical coverage ends, the subscriber and their dependents covered by this medical plan may be eligible to continue SEBB medical coverage during temporary or permanent loss of eligibility.

There are three options the subscriber and their dependents may qualify for when coverage ends.

- SEBB Continuation Coverage (COBRA)
- SEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage, this may include school employees separating from employment

A subscriber also has the right to convert to individual medical insurance coverage with the plan when continuation of group medical insurance coverage is no longer possible.

SEBB Continuation Coverage

The SEBB Program administers the following continuation coverage options to temporarily extend group insurance coverage when the enrollee's SEBB medical plan coverage ends due to a qualifying event:

- **SEBB Continuation Coverage (COBRA)** includes eligibility and administrative requirements under federal COBRA laws and regulations. Some enrollees who are not qualified beneficiaries under federal COBRA, may also qualify for SEBB Continuation Coverage (COBRA).
- **SEBB Continuation Coverage (Unpaid Leave)** is an option created by the SEBB Program with wider eligibility criteria and qualifying event types than COBRA.

An enrollee who qualifies for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may enroll in only one of these options. See "Continuation coverage enrollment" and the *SEBB Continuation Coverage Election Notice* sent by the SEBB Program.

Premium payments for SEBB Continuation Coverage

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges.

PEBB Retiree Insurance Coverage

A retiring school employee, a separating school employee who is at least age 55 and meets specific retirement plan and years of service requirements, or a dependent becoming eligible as a survivor is eligible to continue enrollment or defer (postpone) enrollment in Public Employees Benefits Board (PEBB) insurance coverage if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Transitional Continuation Coverage

Non-represented educational service district (ESD) school employees and their dependents may gain temporary eligibility for SEBB benefits, on a self-pay basis, if they meet the following criteria:

- A non-represented ESD school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB organization on December 31, 2023, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to continue existing enrollment in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of 18 months.
- A dependent of a SEBB eligible non-represented school employee of an ESD who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2023, who loses eligibility because they are not an eligible dependent may continue existing enrollment for a maximum of 36 months.
- A dependent of a non-represented school employee who is continuing medical, dental, or vision coverage through an ESD on December 31, 2023, may elect to continue existing enrollment to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program.

Family and Medical Leave Act of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the federal FMLA.

The SEBB organization or the employer group determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period.

If a school employee exhausts the period of leave approved under FMLA, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the SEBB organization or the employer group. See “Options for continuing SEBB medical coverage.”

Paid Family and Medical Leave Act

A school employee on approved leave under the Washington state Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward SEBB benefits.

The Employment Security Department determines if the school employee is eligible for leave under PFML. The school employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period.

If a school employee exhausts the period of leave approved under PFML, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the SEBB organization or the employer group. See “Options for continuing SEBB medical coverage.”

Conversion of Coverage

An enrollee has the right to switch from SEBB group medical to an individual conversion plan offered by this plan when they are no longer eligible to continue the SEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care.

An enrollee must apply for conversion coverage and pay the first month’s premium no later than 31 days after their SEBB group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later. The conversion coverage will become effective immediately following termination of coverage under the SEBB group medical plan.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of this conversion plan differ from those of the enrollee’s current group medical plan. To receive detailed information on conversion options under this medical plan, call us at 1-800-807-7310 (TRS: 711).

General provisions for eligibility and enrollment

Payment of premiums during a labor dispute

Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB organization or the employer group may pay premiums directly to HCA if the school employee's compensation is suspended or terminated directly or indirectly because of a strike, lockout, or any other labor dispute, for a period not to exceed six months.

When the school employee's compensation is suspended or terminated, HCA will notify the school employee immediately, by mail at the last address of record, that the school employee may pay premiums as they become due.

If coverage is no longer available to the school employee under this certificate of coverage, then the school employee may be eligible to purchase an individual medical plan from this plan consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Appeal rights

Any current or former school employee of a SEBB organization or their dependent may appeal a decision made by the SEBB organization regarding SEBB eligibility, enrollment, or premium surcharges to the SEBB organization.

Any current or former school employee of an employer group that contracts with HCA for SEBB benefits, or their dependent may appeal a decision made by an employer group regarding SEBB eligibility, enrollment, or premium surcharges to the employer group.
Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or premium surcharges to the SEBB Appeals Unit.

Any enrollee may appeal a decision regarding the administration of a SEBB medical plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Learn more at hca.wa.gov/sebb-appeals.

Relationship to law and regulations

Any provision of this certificate of coverage that is in conflict with any governing law or regulation of Washington tate is hereby amended to comply with the minimum requirements of such law or regulation

Other Plan Information

This section tells you about how your Group's contract with us and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you. If you have any questions about your plan or want to request additional information or forms, please call customer service or go to our website at premera.com/sebb. Information about your plan is provided to you free of charge.

Benefit Modifications	From time to time, we may change the terms of this contract. You will receive prior written notice of any changes, and 30 days prior written notice of changes to premiums (see ***Notice***). If the terms of this contract change, those changes will not affect benefits to a member during confinement in a facility. Benefit changes will take effect when you leave the facility, or from any other facility you are transferred to, as long as you are still covered under this plan. No producer or agent of PBC HMO or any other person, is authorized to make any changes, additions, or deletions to this contract or to waive any provision of this contract. Changes, alterations, additions, or exclusions can only be done with the signature of an officer of PBC HMO.
Benefits Not Transferable	No person other than you is entitled to receive the benefits of this contract. Such right to these benefits is not transferable. Fraudulent use of such benefits will result in cancellation of your eligibility under this contract and appropriate legal action.
Conformity with the Law	The Group Contract is issued and delivered in the State of Washington and is governed by the laws of the State of Washington, except to the extent pre-empted by federal law. If any provision of the Group Contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon

	discovery of such conflict the Group Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.
Entire Contract	The entire contract between the Group and us consists of all of the following: • The contract face page and "Standard Provisions" • This benefit booklet(s) • The Group's signed application • All attachments, endorsements, and riders included or issued hereafter No representative of Premera Blue Cross HMO or any other entity is authorized to make any changes, additions or deletions to the Group Contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done with the signature of an officer of Premera Blue Cross HMO. If there is a language conflict in the contract, the benefit booklet (as amended by any attachments, endorsements or riders) will govern.
Evidence of Medical Necessity	We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you, or on your behalf by your healthcare providers. No benefits will be available if the proof isn't provided or acceptable to us.
The Group and You	The Group is your representative for all purposes under this plan and not the representative of Premera Blue Cross HMO. Any action taken by the Group will be binding on you.
Health Care Providers - Independent Contractors	All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this contract are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.
ID Card	If you need a replacement PBC HMO ID card, call our customer service or visit our website at premera.com/sebb If coverage under the contract terminates, your PBC HMO ID card will no longer be valid.
Intentionally False or Misleading Statements	If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, we'll be entitled to recover these amounts. see ***Right of Recovery*** later in this section. And, if a member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the member's acceptability for coverage, we may, at our option: • Deny the member's claim. • Reduce the amount of benefits provided for the member's claim. • Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all). Finally, statements that are fraudulent, intentionally false or misleading on any group form required by us, that affect the acceptability of the Group or the risks to be assumed by us, may cause the Group Contract for this plan to be voided. **Note:** We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.
Limitations of Liability	We are not legally responsible for any of the following: • Epidemics, disasters, or other situations that prevent members from getting the care they need. • The quality of services or supplies that members get from providers, or the amounts charged by providers.

	• Providing any type of hospital, medical, dental, vision, or similar care. • Harm that comes to a member while in a provider's care. • Amounts in excess of the actual cost of services and supplies. • Amounts in excess of this plan's maximums. This includes recovery under any claim of breach. • General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages.
Member Cooperation	You're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.
Newborn's and Mother's Health Protection Act	Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours).
Notice	We may be required to send you certain notices. We will consider such a notice to be delivered if we mail or email it to your most recent mailing or email address in our records. The date of the postmark or email is the delivery date. If you are required to send notice to us, the postmark date will be the delivery date. If not postmarked, the delivery date will be the date we receive it.
Notice of Information Use and Disclosure	We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources. This information is collected, used or disclosed for conducting routine business operations such as: • Determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.). • Coordinating benefits with other healthcare plans. • Conducting care management, case management, or quality reviews. • Fulfilling other legal obligations that are specified under the Group contract. This information may also be collected, used or disclosed as required or permitted by law. To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it. If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization. You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our customer service department and ask a representative to mail a request form to you.
Notice of Other Coverage	As a condition of receiving benefits under this plan, you must notify us of:

	• Any legal action or claim against another party for a condition or injury for which we provide benefits; and the name and address of that party's insurance carrier. • The name and address of any insurance carrier that provides: • Personal injury protection (PIP). • Underinsured motorist coverage. • Uninsured motorist coverage. • Any other insurance under which you are or may be entitled to recover compensation. • The name of any other group or individual insurance plans that cover you.
Rights of Assignment	Notwithstanding any other provision in this contract, and subject to any limitations of state or federal law, in the event that we merge or consolidate with another corporation or entity, or do business with another entity under another name, or transfer this contract to another corporation or entity, this contract shall remain in full force and effect, and bind the subscriber and the successor corporation or other entity. We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.
Right of Recovery	We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us. In addition, if this contract is voided as described in ***Intentionally False or Misleading Statements***, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.
Right to and Payment of Benefits	Benefits of this plan are available only to members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan. At our option only and in accordance with the law, we may pay the benefits of this plan to: • The subscriber. • A provider. • Another health insurance carrier. • The member. • Another party legally entitled under federal or state medical child support laws. • Jointly to any of the above. Payment to any of the above satisfies our obligation as to payment of benefits.
Venue	All suits or legal proceedings brought against us by you or anyone claiming any right under this plan must be filed: • Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable. • In the state of Washington or the state where you reside or are employed.

	All suits or legal or arbitration proceedings brought by us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in King County, the state of Washington.
Women's Health and Cancer Rights Act of 1998	Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Please see ***Covered Services***.
Workers' Compensation Insurance	This contract is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera Blue Cross HMO has arrangements with other Blue Cross and Blue Shield Licensees ("Host Blues") for care outside our service area. These arrangements are called "Inter-Plan Arrangements". Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

Premera Blue Cross HMO covers only limited healthcare services received outside of Premera Blue Cross HMO's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care services obtained outside the geographic area Premera Blue Cross HMO serves. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the member's primary care physician or us.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' in-network providers. The Host blue is responsible for its in-network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (non-contracted providers). ***Out-Of-Area Care*** explains how the plan pays both types of providers.

When you get services through these Inter-Plan Arrangements, it does not change what the plan covers, benefit levels, or any stated eligibility requirements. Please call us if your care needs a prior authorization.

We process claims for the ***Prescription Drugs*** benefit directly, not through an Inter-Plan Arrangement.

BlueCard Program

Except for copays, we will base the amount you must pay for claims from Host Blues' in-network providers on the lower of:

- The provider's billed charges for your covered services; or
- The allowed amount that the Host Blue made available to us.

Often, the "allowed amount" is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

Host Blues may use a number of factors to set estimated or average prices. These may include settlements, incentive payments, and other credits or charges. Host Blues may also need to adjust their prices to correct their estimates of past prices. However, we will not apply any further adjustments to the price of a claim that has already been paid.

Taxes, Surcharges and Fees

A law or regulation may require a surcharge, tax or other fee be added to the price of a covered service. If that happens, we will add that surcharge, tax or fee to the allowed amount for the claim.

Non-Contracted Providers

It could happen that you receive covered services from providers outside our service area that do not have a contract with the Host Blue. In most cases we will base the amount you pay for such services on either our

allowed amount for these providers or the pricing requirements under applicable law. See the definition of "allowed amount" in ***Important Plan Information*** of this booklet for details on allowed amounts.

In these situations, you may owe the difference between the amount that the non-contracted provider bills and the payment the plan makes for the covered services as set forth above.

Blue Cross Blue Shield Global® Core

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core. Blue Cross Blue Shield Global® Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global® Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***How Do I File a Claim*** for more information. However, if you need hospital inpatient care, the service Center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at 800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 804-673-1177.

More Questions

If you have questions or need to find out more about the BlueCard Program or Blue Cross Blue Shield Global® Core, please call our customer service department. You can find a provider on premera.com/sebb or by calling 800-810-BLUE (2583).

ADDITIONAL INFORMATION ABOUT YOUR COVERAGE

Your benefit booklet provides you with detailed information about this plan's benefits, limitations and exclusions, how to obtain care and how to appeal our decisions.

You may also ask for the following information:

- Your right to seek and pay for care outside of this plan.
- The plan's formulary drug list.
- How we pay providers.
- How providers' payment methods help promote good patient care.
- A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations.
- How to file a complaint and a copy of our process for resolving complaints.
- How to access specialists.
- Obtaining a prior authorization when needed.
- Accreditation by national managed care organizations.
- Use of the health employer data information set (HEDIS) to track performance.

If you want to receive this information, please go to our website at premera.com/sebb. If you don't have access to the web, please call customer service.

Definitions

The information here will help you understand what these words mean. We have the responsibility and authority to use our expertise and judgment to reasonably construe the terms of this contract as they apply to specific eligibility and claims determinations. For example, we use the medical judgment and expertise of Medical Directors to determine whether claims for benefits meet the definitions below of "Medical Necessity" or "Experimental/Investigative Services." We also have medical experts who determine whether care is custodial care or skilled care and reasonably interpret the level of care covered for your medical condition. This does not prevent you from exercising your rights you may have under applicable law to appeal, have independent review or bring a civil challenge to any eligibility or claims determinations.

Accidental Injury	Physical harm caused by a sudden, unexpected event at a certain time and place.

	Accidental injury does not mean any of the following: • An illness, except for infection of a cut or wound • Dental injuries caused by biting or chewing • Over-exertion or muscle strains
Adverse Benefit Determination	An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes • A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage • A limitation on otherwise covered benefits • A clinical review decision • A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective • A decision related to compliance with protections against balance billing as defined by federal and state law
Affordable Care Act	The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
Ambulatory Surgical Center	A healthcare facility that's licensed or certified as required by the state it operates in and that meets all of the following: • It has an organized staff of physicians. • It has permanent facilities that are equipped and operated mainly for the purpose of performing surgical procedures. • It doesn't provide inpatient services or accommodations.
Annual Open Enrollment	A period of time defined by HCA when a subscriber may change to another health plan offered by the SEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.
Applied Behavioral Analysis (ABA)	The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.
Autism Spectrum Disorders	Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, as amended or reissued from time to time.
Benefit	What this plan provides for a covered service. The benefits you get are subject to this plan's cost-shares.
Benefit Booklet	Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.

Calendar Year	The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.
Claim	A request for payment from us according to the terms of this plan.
Clinical Trials	An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by one of the following: • An institutional review board that complies with federal standards for protecting human research subjects; and • The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers • United States Food and Drug Administration (FDA) • The United States Department of Defense • The United States Department of Veterans' Affairs • A nongovernmental research entity abiding by current National Institutes of Health guidelines
Congenital Anomaly	A marked difference from the normal structure of an infant's body part that's present from birth.
Contract	Contract describes the benefits, limitations, exclusions, eligibility, and other coverage provisions included in this plan.
Continuation Coverage	The temporary continuation of SEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or SEBB policies.
Cosmetic Services	Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This includes drugs, services, or supplies to improve or alter the appearance of your skin or hair.
Cost-Share	The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.
Covered Service	A service, supply or drug that is eligible for benefits under the terms of this Plan.
Custodial Care	Any portion of a service, procedure, or supply that is provided primarily: • For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury • To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervising over self-administration of medication not requiring constant attention of trained medical personnel.

Dependent	An eligible spouse, state-registered domestic partner, child, or other eligible family member as described in the ***Dependent Eligibility*** section of this certificate that is enrolled or eligible to be enrolled by this plan under the subscriber's account.
Detoxification	Active medical management of substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance taken, repeated vital sign monitoring, and use of medication to manage intoxication or withdrawal. Observation without active medical management, or any service that is claimed to be detoxification but does not include active medical management, is not detoxification.
Doctor (also called "Physician")	A state-licensed: • Doctor of Medicine and Surgery (MD). • Doctor of Osteopathy (DO).
Donor Human Milk	Human milk that has been contributed to a milk bank by one or more donors.
Effective Date	The date when your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.
Eligibility Waiting Period	The length of time that must pass before a subscriber or dependent is eligible to be covered under the Group's health care plan. If a subscriber or dependent enrolls under the ***Special Enrollment*** provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.
Emergency Medical Condition (also called "Emergency")	A medical, mental health, or substance use disorder condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.
Emergency Services	• A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services given in an emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health. • Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary

	to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery. • Ambulance transport as needed in support of the services above.
Employer group	An employee organization representing school employees and a tribal school as defined in RCW 28A.715.010, obtaining school employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the SEB board.
Endorsement	A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.
Enrollee or Member (also called "You" and "Your")	A person covered under this plan as a subscriber or dependent.
Experimental/Investigative Services	A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria: • A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided. • It is subject to oversight by an Institutional Review Board. • There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition. • It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. • Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies. Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).
Explanation of Benefits	An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.
Facility (Medical Facility)	A hospital, skilled nursing facility, approved treatment facility for chemical dependency, state-approved institution for treatment of mental or psychiatric conditions, or hospice. Not all health care facilities are covered under this contract.
Group	The employer that is a party to the Group Contract. The Group is responsible for collecting and paying all premiums, receiving notice of additions and changes to employee and dependent eligibility (including determination) and providing such notice to us, and acting on behalf of its employees.
Health Care Benefit Managers	Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee

	benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.
Health Care Authority (HCA)	The Washington State agency that administers the PEBB and SEBB Programs.
Home Health Agency	An organization that provides covered home health care services to a member.
Home Medical Equipment (HME)	Equipment ordered by a healthcare provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as "Durable Medical Equipment" or "DME."
Hospice	A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill. Care is focused on comfort and not intended to cure or improve the medical or functional outcome of a patient's condition or to prepare the patient for outpatient care settings.
Hospital	A healthcare facility that meets all of these criteria: • It operates legally as a hospital. • It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients. • It has a staff of providers that provides or supervises the care. • It has 24-hour nursing services provided by or supervised by registered nurses. A facility is not considered a hospital if it operates mainly for any of the purposes below: • As a rest home, nursing home, or convalescent home. • As a residential treatment center or health resort. • To provide hospice care for terminally ill patients. • To care for the elderly. • To treat substance use disorder or tuberculosis.
Illness	A sickness, disease, or medical condition.
Injury	Physical harm caused by a sudden event at a specific time and place. It is independent of illness, except for infection of a cut or wound.
In-Network Pharmacy (In-Network Retail/In-Network Mail Order Pharmacy)	A licensed pharmacy which contracts with us or our Pharmacy Benefit Manager to provide prescription drug benefits.
Inpatient	Confined in a medical facility or as an overnight bed patient.

Lifetime Maximum	The maximum amount that PBC HMO will provide during your lifetime.
Long-term Care Facility	A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.023, or assisted living facility licensed under chapter 18.20 RCW.
Maternity Care (Obstetrical Care)	health services you get during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy. This includes the time during pregnancy and within 45 days following delivery.
Medical Equipment	Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.
Medically Necessary and Medical Necessity	Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must: • Agree with generally accepted standards of medical practice • Be clinically appropriate in type, frequency, extent, site and duration., They must also be considered effective for the patient's illness, injury or disease • Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
Mental Health Conditions	A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance use disorder.
Milk Bank	An organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.
Observation	Monitoring and evaluation at a Hospital or other facility in order to determine whether an inpatient stay is required.
Orthotic	A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.
Outpatient	**Treatment received in a setting other than as inpatient in a medical facility.**
Out-Of-Network Provider	A provider that is not in the provider network stated in the ***How Providers Affect Your Costs*** section.

Outpatient Surgical Center	A facility that's licensed or certified as required by the state it operates in and that meets all of the following: • It has an organized staff of physicians • It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures • It doesn't provide inpatient services or accommodations.
Pharmacy Benefit Manager	An entity that contracts with us to administer the ***Prescription Drugs*** benefit under this plan.
Plan	The benefits, terms and limitations set forth in the contract between us and the Group, of which this booklet is a part. In the ***Eligibility*** sections, "plan" may mean a plan other than Premera HMO not sponsored by the SEBB Program.
Premium	The monthly rates we establish as consideration for the benefits offered under this contract.
Prescription Drugs	Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription." Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by: One of the following standard reference compendia: • The American Hospital Formulary Service-Drug Information • The American Medical Association Drug Evaluation • The United States Pharmacopoeia-Drug Information • Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts) "Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling. Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.
Primary Care Provider (PCP)	A provider who both provides primary care and coordinates care to other medical services. See ***Primary Care Providers*** on page 7 for a list of provider types that fall under PCP.

Prior Authorization	Prior authorization is a process that requires you or a provider to follow before a service is given, to determine if a service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care or effectiveness. You must ask for prior authorization before the service is delivered. See ***Prior Authorization*** for details.
Provider	A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care-related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of their employment. Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law. Covered categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met: The providers are: • Acupuncturists (LAc) (In Washington also called East Asian Medicine Practitioners (EAMP)). • Audiologists. • Chiropractors (DC). • Counselors. • Dental Hygienists (under the supervision of a DDS or DMD). • Dentists (DDS or DMD). • Denturists. • Dietitians and Nutritionists (D or C., or CN). • Home Health Care, Hospice and Home Care Agencies. • Marriage and Family Therapists. • Massage Practitioners (LMP). • Midwives. • Naturopathic Physicians (ND). • Nurses (RN, LPN, ARNP, or NP). • Nursing Homes. • Obstetricians (MD) • Occupational Therapists (OTA). • Ocularists. • Opticians (Dispensing). • Optometrists (OD). • Osteopathic Physician Assistants (OPA) (under the supervision of a D.O.). • Osteopathic Physicians (DO). • Pharmacists (RPh).

	• Physical Therapists (LPT). • Physician Assistants (PA) (under the supervision of an MD). • Physicians (MD). • Podiatric Physicians (DPM). • Psychologists (PhD). • Radiologic Technologists (CRT, CRTT, CRDT, CNMT). • Respiratory Care Practitioners. • Social Workers. • Speech-Language Pathologists. The following healthcare facilities and other providers will also be considered providers for the purposes of this plan when they meet requirements above. • Ambulance Companies. • Ambulatory Diagnostic, Treatment and Surgical Facilities. • Audiologists (CCC-A or CCC-MSPA). • Birthing Centers. • Blood Banks. • Board Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed in states that have specific licensure for behavior analysts. • Community Mental Health Centers. • Drug and Alcohol Treatment Facilities. • Medical Equipment Suppliers. • Hospitals. • Kidney Disease Treatment Centers (Medicare-certified). • Psychiatric Hospitals. • Speech Therapists (Certified by the American Speech, Language and Hearing Association). In states other than Washington, "provider" means healthcare practitioners and facilities that are licensed or certified consistent with the laws and regulations of the state in which they operate. This plan makes use of provider networks as explained in ***How Providers Affect Your Costs***.
Psychiatric Condition	A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance use disorder.
Public Employees Benefits Board (PEBB)	A group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.
Public Employees Benefits Board (PEBB) Program	The HCA program that administers PEBB benefit eligibility and enrollment.
Reconstructive Surgery	Is surgery: • That restores features damaged as a result of injury or illness

	• To correct a congenital deformity or anomaly
Rehabilitation Therapy	Rehabilitation therapy or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition. Rehabilitation therapy includes physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope of their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.
School Board Member	The board of directors of a school district as governed by chapter 28A.343 RCW or the board of directors of an educational service district as governed by chapter 28A.310 RCW who is self-paying for SEBB health plan coverage.
School Employees Benefits Board (SEBB)	A group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.
School Employees Benefits Board (SEBB) Organization	A public school district or educational service district or charter school established under Washington state statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).
School Employees Benefits Board (SEBB) Program	The program within HCA that administers insurance and other benefits for eligible school employees, eligible dependents, and eligible school board members.
Service Area	King, Pierce, Spokane, and Thurston counties in Washington State.
Services	Services are procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.
Skilled Nursing Care	Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.
Skilled Nursing Facility	A medical facility licensed by the state to provide nursing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.
Specialist	A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse	• An individual who is legally married to the subscriber • An individual who is a domestic partner of the subscriber.
Subscriber	A school employee, a school board member, or a continuation coverage enrollee who has been determined eligible and is enrolled in this plan, and is the individual to whom the SEBB Program or We will issue notices, information, requests, and premium bills on behalf of an Enrollee.
Substance Use Disorder Conditions	Substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.
Urgent Care	Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away, but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.
Virtual Care	Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused.
Visit	A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.
We, Us and Our	Premera Blue Cross HMO

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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.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ 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 HMO 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 Blue Cross HMO does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera Blue Cross HMO 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 Blue Cross HMO 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 Blue Cross HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TRS: 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.

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