INTRODUCTION

Premera Blue Cross 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. This booklet replaces any other benefit booklet you may have received. The Group has delegated authority to Premera Blue Cross 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.

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see Definitions). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

Premera Blue Cross believes this plan is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of the plan lifetime maximum.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to lose its grandfathered health plan status, can be directed to the Group's plan administrator. You may also contact the federal Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Group Name: SAMPLE
Effective Date: January 1, 2018
Group Number: SAMPLE
Plan: Your Choice (Grandfathered)
Certificate Form Number: YCWL (01-2018)
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services,
200 Independence Ave SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019,

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

አማርኛ (Amharic):
አማርኛ

العربية (Arabic):

العربية

中文 (Chinese):

本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Kreyòl ayisyen (Creole):

Italiano (Italian):
한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉
이 통지서는 귀하의 신청에 관하여 그리고
Premera Blue Cross를 통한 커버리지에 관한
정보를 포함하고 있을 수 있습니다. 본
통지서에는 핵심이 되는 난沢들이 있을 수
있으니 귀하의 건강 커버리지를 계속
유지하거나 비용을 절약하기 위해서 일정한
마감일까지 조치를 취해야 할 필요가 있을 수
있으니 귀하는 이러한 정보의 활용도 귀하의
연여로 비용 부담없이 일을 할 수 있는 권리가
있습니다. 800-722-1471 (TTY: 800-842-5357)로
전화하십시오.

Farsi (Persian):
این اطلاعات مربوط به اطلاعات مهم میباشد این اطلاعات ممكن است
حائز اطلاعات مهم در درمان بیماری و درمان بیماری از
بیماری باشد. مراجعه به Premera Blue Cross
قرار داشته باشید. اطلاعات مهم می‌باشد
ارائه می‌گردد. Premera Blue Cross
در این مورد مراجعه کنید. مراجعه به Premera Blue Cross
در این مورد مراجعه کنید. مراجعه به Premera Blue Cross
مراجعه به Premera Blue Cross. 800-722-1471 (TTY: 800-842-5357)

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To
ogłoszenie może zawierać ważne informacje odnośnie
Państwa wniosku lub zakresu świadczeń poprzez
Premera Blue Cross. Prosimy zwrócić uwagę na
kluczowe daty, które mogą być zawarte w tym ogłoszeniu
aby nie przekroczyć terminów w przypadku utrzymania
polisy ubezpieczeniowej lub pomocy związanej z
kosztami. Macie Państwo prawo do bezpłatnej informacji
we własnym języku. Zadzwoń pod 800-722-1471
(TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este
aviso poderá conter informações importantes a respeito
de sua aplicação ou cobertura por meio do Premera Blue
Cross. Poderão existir dados importantes neste aviso.
Talvez seja necessário que você tome providências
dentro de determinados prazos para manter sua
cobertura de saúde ou ajuda de custos. Você tem o
direito de obter esta informação e ajuda em seu idioma e
sem custos. Ligue para 800-722-1471
(TTY: 800-842-5357).
Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страховочного покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).
HOW TO USE THIS BOOKLET
This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

• How Does Selecting A Provider Affect My Benefits? — how using network providers will cut your costs
• What Types Of Expenses Am I Responsible For Paying?
• What Are My Benefits? — what's covered and what you need to pay for covered services.
• Prior Authorization – Describes the plan's prior authorization and emergency admission notification requirement.
• What's Not Covered? — services that are either limited or not covered under this plan
• Who Is Eligible For Coverage? – eligibility requirements for this plan
• How Do I File A Claim? — step-by-step instructions for claims submissions
• Complaints And Appeals — processes to follow if you want to file a complaint or an appeal
• Definitions — terms that have specific meanings under this plan. Example: “You” and “your” refer to members under this plan. “We,” “us” and “our” refer to Premera Blue Cross in Washington and Premera Blue Cross Blue Shield of Alaska in Alaska.

FOR MORE INFORMATION
You'll find our contact information on the back cover of this booklet. Please call or write Customer Service for help with:

• Questions about benefits or claims
• Questions or complaints about care you receive
• Changes of address or other personal information

You can also get benefit, eligibility and claim information through our Interactive Voice Response system when you call.

Online information about your plan is at your fingertips whenever you need it
You can use our Web site to:

• Locate a health care provider near you
• Get details about the types of expenses you're responsible for and this plan's benefit maximums
• Check the status of your claims
• Visit our health information resource to learn about diseases, medications, and more
TABLE OF CONTENTS

CONTACT US ........................................................... (SEE BACK COVER OF THIS BOOKLET)

GETTING HELP IN OTHER LANGUAGES ................................................................. i

HOW TO USE THIS BOOKLET ............................................................................... v

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS? ................................. 1

- Network Providers .............................................................................................. 1
- Non-Network Providers ........................................................................................ 1
- In-Network Benefits For Non-Network Providers ................................................. 2

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING? .............................. 2

- Copayments ........................................................................................................ 2
- Calendar Year Deductible ..................................................................................... 3
- Coinsurance .......................................................................................................... 3
- Out-Of-Pocket Maximum ..................................................................................... 3

WHAT ARE MY BENEFITS? ..................................................................................... 4

- What Are My Cost-Shares? .................................................................................. 4
- What Are My Copays? .......................................................................................... 4
- Inpatient Admission Copay .................................................................................. 4
- Emergency Room Copay ...................................................................................... 5
- Ambulance Copay ............................................................................................... 5
- Professional Visit Copay ..................................................................................... 5
- What’s My Calendar Year Deductible? ................................................................. 5
- What’s My Coinsurance? ..................................................................................... 5
- What’s My Out-Of-Pocket Maximum? ................................................................. 6

Medical Services .................................................................................................. 6

- Acupuncture Services .......................................................................................... 6
- Ambulance Services ............................................................................................. 6
- Ambulatory Surgical Center Services ................................................................... 6
- Assisted Reproduction ......................................................................................... 7
- Blood Products and Services .............................................................................. 7
- Clinical Trials ...................................................................................................... 8
- Contraceptive Management and Sterilization ....................................................... 8
- Dental Services ................................................................................................... 9
- Diagnostic Services ............................................................................................ 10
- Diagnostic and Screening Mammography ......................................................... 11
- Dialysis ............................................................................................................... 11
- Emergency Room Services ................................................................................ 12
- Foot Care ........................................................................................................... 12
Prior Authorization Penalty ................................................................................................................. 42
Exceptions .............................................................................................................................................. 42
Prior Authorization For Prescription Drugs ......................................................................................... 43
Prior Authorization For Non-Network Providers .................................................................................. 43
Clinical Review ........................................................................................................................................ 43
WHAT’S NOT COVERED? ......................................................................................................................... 44
Waiting Period For Transplants ............................................................................................................... 44
Limited And Non-Covered Services ........................................................................................................ 44
WHAT IF I HAVE OTHER COVERAGE? ...................................................................................................... 49
Coordinating Benefits With Other Health Care Plans ............................................................................ 49
COB Definitions ....................................................................................................................................... 49
Primary And Secondary Rules .................................................................................................................. 50
COB’s Effect On Benefits ........................................................................................................................... 51
Subrogation And Reimbursement ............................................................................................................ 51
Uninsured And Underinsured Motorist/Personal Injury Protection Coverage ...................................... 52
WHO IS ELIGIBLE FOR COVERAGE? ......................................................................................................... 52
Subscriber Eligibility .................................................................................................................................. 52
Dependent Eligibility .................................................................................................................................. 53
WHEN DOES COVERAGE BEGIN? ................................................................................................................... 53
Enrollment ................................................................................................................................................ 53
Natural Newborn Children Born On Or After The Subscriber’s Effective Date ................................... 53
Adoptive Children Acquired On Or After The Subscriber’s Effective Date ........................................... 54
Foster Children ......................................................................................................................................... 54
Children Acquired Through Legal Guardianship ..................................................................................... 54
Children Covered Under Medical Child Support Orders ..................................................................... 54
Special Enrollment ..................................................................................................................................... 54
Involuntary Loss of Other Coverage ........................................................................................................ 54
Subscriber And Dependent Special Enrollment ...................................................................................... 55
State Medical Assistance and Children’s Health Insurance Program ..................................................... 55
Open Enrollment ........................................................................................................................................ 55
Changes In Coverage .................................................................................................................................. 55
Plan Transfers ............................................................................................................................................ 55
WHEN WILL MY COVERAGE END? .................................................................................................................. 56
Events That End Coverage ....................................................................................................................... 56
Contract Termination ................................................................................................................................. 56
HOW DO I CONTINUE COVERAGE? ........................................................................................................... 57
Continued Eligibility For A Disabled Child ............................................................................................. 57
Leave Of Absence ...................................................................................................................................... 57
HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

This plan's benefits and your out-of-pocket expenses depend on the providers you see. In this section you’ll find out how the providers you see can affect this plan's benefits and your costs.

This plan makes available to you sufficient numbers 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 networks include hospitals, physicians, and a variety of other types of providers.

Network Providers

This plan is a Preferred Provider Plan (PPO). This means that the plan provides you benefits for covered services from providers of your choice. Its benefits are designed to provide lower out-of-pocket expenses when you receive care from network providers. There are some exceptions, which are explained below.

Network providers are:

- Providers in the Heritage Prime network in Washington. For care in Clark County, Washington, you also have access to providers through the BlueCard® Program.
- Providers in Alaska that have signed contracts with Premera Blue Cross Blue Shield of Alaska.
- For care outside the service area (see Definitions), providers in the local Blue Cross and/or Blue Shield Licensee's network shown below. (These Licensees are called “Host Blues” in this booklet.) See Out-Of-Area Care later in the booklet for more details.
  - Wyoming: The Host Blue's Traditional (Participating) network
  - All Other States: The Host Blue's PPO (Preferred) network

Participating pharmacies are also network providers and are available nationwide.

Network providers provide medical care to members at negotiated fees. These fees are the allowable charges for network providers. When you receive covered services from a network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). Network providers will not charge you more than the allowable charge for covered services. This means that your portion of the charges for covered services will be lower.

Your choice of a particular provider may affect your out-of-pocket costs because different providers may have different allowable charges even though they all have an agreement with us or with the same Host Blue. You'll never have to pay more than your share of the allowable charge for covered services when you use network providers.

A list of network providers is in our Heritage Prime provider directory. You can access the directory at any time on our Web site at www.premera.com. You may also ask for a copy of the directory by calling Customer Service. The providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. You can also call the BlueCard provider line to locate a network provider. The numbers are on the back cover of this booklet and on your Premera Blue Cross ID card.

We update this directory regularly but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location or their provider group is in the Heritage Prime network.

Important Note: You’re entitled to receive a provider directory automatically, without charge.

Non-Network Providers

Non-network providers are providers that are not in one of the networks shown above. Your bills will be reimbursed at a lower percentage (the out-of-network benefit level). This means higher cost-shares for you, as shown in What Are My Benefits? below.

- Some providers in Washington that are not in the Heritage Prime network do have a contract with us. Even though your bills will be reimbursed at the lower percentage (the non-network benefit level), these providers will not bill you for any amount above the allowable charge for a covered service. The same is true for a provider that is in a different network of the local Host Blue.
• There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers are called “non-contracted” providers in this booklet. Their covered services are based on a lower allowable charge. See Definitions. “Non-contracted” providers have the right to charge you more than the allowable charge for a covered service. You may also be required to submit the claim yourself. See How Do I File A Claim? for details.

Amounts in excess of the allowable charge don’t count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Services you receive in a network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are non-network providers. When you receive services from these non-network providers, you may be responsible for amounts over the allowable charge as explained above.

In-Network Benefits For Non-Network Providers

The following covered services and supplies provided by non-network providers will always be covered at the in-network level of benefits:

• Emergency care for a medical emergency. (Please see the Definitions section for definitions of these terms.) This plan provides worldwide coverage for emergency care.

The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is a network provider. Emergency care furnished by a non-network provider will be reimbursed at the in-network benefit level. As explained above, if you see a non-network provider, you may be responsible for amounts that exceed the allowable charge.

• Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.

• Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.

• Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Heritage Prime provider who doesn’t have admitting privileges at a Heritage Prime hospital.

• Covered services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

If a covered service is not available from a network provider, you can receive benefits for services provided by a non-network provider at the in-network benefit level. However, you must request this before you get the care. See Prior Authorization to find out how to do this.

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

This section of your booklet explains the types of expenses you must pay for covered services before the benefits of this plan are provided. (These are called “cost-shares” in this booklet.) To prevent unexpected out-of-pocket expenses, it’s important for you to understand what you’re responsible for. You’ll find the dollar amounts for these expenses and when they apply in the What Are My Benefits? section.

COPAYMENTS

Copayments (hereafter referred to as “copays”) are fixed up-front dollar amounts that you’re required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service.

The copays applicable to the Medical Services portion of this plan are located under the What Are My Copays? provision in the What Are My Benefits? section later in this booklet. Any benefits that are subject to different copays will state those amounts in the benefit.

After your copay, other than Emergency Room Services, benefits subject to a copay aren’t subject to your deductible, coinsurance, or out-of-pocket maximum, if any.

Please refer to the Emergency Room Services benefit under the What Are My Benefits? section for more details.

If all you have to pay is a copay for a covered service or supply, it is not considered a claim for benefits. However, you always have the right to get a paper copy of your explanation of benefits for the service or supply.
You can call Customer Service. The phone number is on the back cover of your booklet and on your Premera ID card. Or, you can visit our website for secure online access to your claims. If your claim is denied in whole or in part, you may send us a complaint or appeal as outlined under “Complaints And Appeals.”

**CALENDAR YEAR DEDUCTIBLE**

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won’t exceed the “allowable charge” (please see the Definitions section in this booklet).

**Individual Deductible**

An “Individual Deductible” is the amount each member must incur and satisfy before certain benefits of this plan are provided.

**Family Deductible**

We also keep track of the expenses applied to the individual deductible that are incurred by all enrolled family members combined. When the total equals a set maximum, called the “Family Deductible,” we will consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member’s individual deductible will count toward the family deductible.

The calendar year deductible amounts applicable to the Medical Services portion of this plan are located under the What Are My Benefits? section.

**What Doesn’t Apply To The Calendar Year Deductible?**

Amounts that don’t accrue toward this plan’s calendar year deductible are:

- Amounts that exceed the allowable charge
- Charges for excluded services
- The penalty for not asking for prior authorization when the plan requires it. See Prior Authorization below in this booklet for details.
- The coinsurance stated in the Prescription Drugs benefit
- Copays

**COINSURANCE**

“Coinsurance” is a defined percentage of allowable charges for covered services and supplies you receive. It's the percentage you’re responsible for, not including copays and the calendar year deductible, when the plan provides benefits at less than 100% of the allowable charge.

The coinsurance percentage applicable to the Medical Services portion of this plan is located under What's My Coinsurance? in the What Are My Benefits? section. Any benefits that are subject to a different coinsurance percentage will state that percentage in the benefit.

**OUT-OF-POCKET MAXIMUM**

The “individual out-of-pocket maximum” is the maximum amount, made up of the calendar year deductible and coinsurance that each individual could pay each calendar year for certain covered services and supplies furnished by network providers. There is no out-of-pocket maximum limit for services of non-network providers.

Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay coinsurance until your individual out-of-pocket maximum is reached.

In addition to benefits shown under the Medical Services section, your plan may have other benefits that are subject to the out-of-pocket maximum. If your plan includes benefits for routine vision or hearing exams and testing, preventive care or orthognathic surgery, any coinsurance and calendar year deductible under these benefits will also accrue to your out-of-pocket maximum. When the plan includes one or more of these benefits, descriptions of each will appear in the Special Benefits section below in this booklet.

We keep track of the total deductible and coinsurance amounts applied to the individual out-of-pocket maximum that are incurred by all enrolled family members combined. When this total equals a set maximum, called the “Family Out-Of-Pocket Maximum,” we will consider the individual out-of-pocket maximum of every enrolled family member satisfied.
member to be met for that calendar year. Only the amounts used to satisfy each enrolled family member’s individual out-of-pocket maximum will count toward the family out-of-pocket maximum.

Please refer to *What’s My Out-of-Pocket Maximum?* in the *What Are My Benefits?* section for the amount of any out-of-pocket maximums you’re responsible for.

Costshares that don’t apply to the out-of-pocket maximum are:

- Amounts that exceed the allowable charge
- Charges for excluded services
- The penalty for not asking for prior authorization when the plan requires it. See *Prior Authorization* in the Care Management section of this booklet.

Once the out-of-pocket maximum has been satisfied, the benefits of this plan will be provided at 100% of allowable charges for the remainder of that calendar year for covered services from network providers.

**WHAT ARE MY BENEFITS?**

This section of your booklet describes the specific benefits available for covered services and supplies. Benefits are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention of (if this plan includes a Preventive Care benefit) or diagnosis and treatment of a covered illness, disease or injury. When included, a description of the Preventive Care benefit will appear in the Special Benefits section later in this booklet.
- It must be medically necessary (please see the Definitions section in this booklet) and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you’re covered under this plan and after any applicable waiting period required under this plan is satisfied.
- It must be furnished by a “provider” (please see the Definitions section in this booklet) who’s performing services within the scope of his or her 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. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. 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). Our policies are available to you and your provider at [www.premera.com](http://www.premera.com) or by calling Customer Service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions throughout this section and the *What’s Not Covered?* section for a complete description of covered services and supplies, limitations and exclusions.

This plan complies with state regulations about coverage for diabetes medical treatment. Please see the Prescription Drugs, Medical Equipment And Supplies, Preventive Care, and Professional Visits And Services, and Health Management benefits.

**WHAT ARE MY COST-SHARES?**

What Are My Copays?

Services subject to a copay when received from a network provider are subject to a calendar year deductible and coinsurance when received from non-network providers.

Inpatient Admission Copay

For each inpatient admission to a network facility, you pay $250.

The inpatient admission copay will apply to the first admission but will be waived for any subsequent admission if you’re directly transferred from one inpatient facility to another. However, if your copay isn’t fully satisfied during your stay at the initial facility you were admitted to, the copay will continue to apply to any subsequent inpatient facilities to which you were directly transferred until it’s fully satisfied.
When you’re admitted to a non-network medical facility for a condition other than a “medical emergency,” the services aren’t subject to an inpatient admission copay, but are subject to a calendar year deductible and coinsurance.

**Emergency Room Copay**

For each emergency room visit, you pay $100. Emergency room visits are also subject to any applicable in-network calendar year deductible and coinsurance. The emergency room copay will be waived if you’re admitted directly to the hospital from the emergency room.

**Ambulance Copay**

For each ambulance service or transport, you pay $50.

**Professional Visit Copay**

For each office or home visit furnished by a network provider, you pay $30.

Certain services don’t require a copay. However, the Professional Visit Copay may apply if you have a consultation with the provider or receive other services. Separate copays will apply if you see more than one network provider on the same day. But only one copay per provider, per day will apply.

In addition to office or home visits, this copay also applies to the following services in an office setting:

- Spinal and other manipulations, acupuncture, biofeedback, rehabilitation therapy, neurodevelopmental therapy.
- Nutritional therapy
- Preventive exams

This copay doesn't apply to the following:

- Services listed under the *Home And Hospice Care* benefit

**What’s My Calendar Year Deductible?**

**Individual Calendar Year Deductible**

For each member, this amount is $1,500 for covered services from network providers.

For covered services from non-network providers, you have a separate calendar year deductible of $3,000.

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don’t count allowable charges that apply to your individual in-network or non-network calendar year deductibles toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to either of your individual calendar year deductibles toward that maximum.

**Please Note:** Each calendar year deductible accrues toward its applicable out-of-pocket maximum, if any.

**Family Deductible**

The maximum calendar year deductible for your family is $3,000 when covered services are received from network providers.

When covered services are received from non-network providers, you have a separate family deductible of $6,000.

**Fourth Quarter Carryover**

Expenses you incur for covered services and supplies in the last 3 months of a calendar year which are used to satisfy all or part of the calendar year deductible will also be used to satisfy all or part of the next year’s deductible. If your plan also includes an out-of-pocket maximum, however, the expenses carried over to satisfy the next year’s deductible will not be applied to the next year’s out-of-pocket maximum.

**What’s My Coinsurance?**

When you see network providers, your coinsurance is 20% of allowable charges.

When you see non-network providers, your coinsurance is 40% of allowable charges.

However, there are a few exceptions to the above coinsurance percentages. Please see the benefits listed below.
What's My Out-Of-Pocket Maximum?

Individual Maximum

For each member, this amount is $4,000 per calendar year, for care from network providers. There is no out-of-pocket maximum limit for services of non-network providers. However, benefits that always apply in-network cost-shares, like Ambulance Services or Emergency Room Services, apply toward the in-network out-of-pocket maximum limit.

Family Maximum

For each family, this amount is $8,000 per calendar year, for care from network providers.

MEDICAL SERVICES

Acupuncture Services

You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If you see a non-network provider, acupuncture benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition.

Benefits are provided for up to 24 visits per member per calendar year.

Ambulance Services

You pay a $50 copay for each ambulance service or transport.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. Transportation to your home is covered when medically necessary. This benefit only covers the member that requires transportation.

Ambulatory Surgical Center Services

The following services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.
Benefits are provided for services and supplies furnished by an ambulatory surgical center.

**Assisted Reproduction**

**Inpatient Facility Services**

You pay a $250 copay for each inpatient admission when you use a network facility.

**Inpatient Professional Services**

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

**Outpatient Surgical Facility Services**

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

**Testing and Surgical Procedures**

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

**Outpatient Professional Visits**

You pay a $30 copay per visit in an office setting when you use a network provider. Please see the *Professional Visit Copay* provision in the *What Are My Benefits?* section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

**Other Professional Services**

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

**Please Note:** If the above assisted reproduction and sterilization reversal services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

This benefit covers assisted reproduction methods. An example is in-vitro fertilization. Also covered are procedures to undo sterilization surgery. Related imaging and lab tests are also covered. Services are covered up to a maximum benefit of $10,000 per member each calendar year for all services combined. These services are not covered under other benefits of this plan.

Take-home drugs to treat infertility or that are required for assisted reproduction procedures are covered under the *Prescription Drugs* benefit. However, these drugs are subject to this benefit’s $10,000 maximum.

This benefit doesn’t cover:

- Testing to determine if a member is infertile. Such tests are covered under the *Diagnostic Services* benefit.
- Medical services to diagnose and correct medical conditions that may cause infertility, including tests to monitor the outcomes. Please see the *Diagnostic Services* and *Surgical Services* benefits.

**Blood Products and Services**

Benefits are provided for blood and blood derivatives, subject to your calendar year deductible and coinsurance when you use a network provider.

**Please Note:** If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

**Chemical Dependency Treatment**

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services. The *Chemical Dependency Treatment* benefit does not have its own benefit maximum.

Most benefits are subject to the same calendar year deductible, coinsurance or copays, if any, that you would pay
for inpatient or outpatient treatment for other covered medical conditions. To find the amounts you are responsible for, please see the What Are My Cost-Shares? section. As the result of applying the federal parity tests, your cost-shares for outpatient facility care for chemical dependency treatment will match the cost share for non-preventive screening services shown in the Diagnostic Services benefit.

Covered services include services provided by a state-approved treatment program or other licensed or certified provider.

The current edition of the Patient Placement Criteria for the Treatment of Substance Related Disorders as published by the American Society of Addiction Medicine is used to determine if chemical dependency treatment is medically necessary.

Please Note: Medically necessary detoxification is covered under the Emergency Room Services and Hospital Inpatient Care benefits.

The Chemical Dependency Treatment benefit doesn’t cover:

- Treatment of alcohol or drug use or abuse that does not meet the definition of “Chemical Dependency” as stated in the Definitions section of this booklet
- Voluntary support groups, such as Alanon or Alcoholics Anonymous
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, unless they are medically necessary
- Halfway houses, quarterway houses, recovery houses, and other sober living residences
- Outward bound, wilderness, camping or tall ship programs or activities

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs are the medically necessary care that is normally covered under this plan for a member who is not enrolled in a clinical trial. The trial must be appropriate for your health condition and you must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service you get. For example, benefits for an office visit are covered under the Professional Visits And Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a phase I, II, III or IV clinical trial that is conducted on the prevention, detection or treatment of cancer or other life-threatening disease or conditions. The trial must also be funded or approved by a federal body, such as one of the National Institutes of Health (NIH), a qualified private research entity that meets the standards for NIH support grant eligibility, or by an institutional review board in Washington that has approval by the NIH Office for Protection from Research Risks.

A “clinical trial” does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed solely to collect data for the trial)
- The investigational item, device or service itself
- A service that is clearly not consistent with widely accepted and established standards of care for a particular condition
- Services, supplies or pharmaceuticals that would not be charged to the member, if there were no coverage.
- Services provided in a clinical trial that are fully funded by another source

We encourage you or your provider to call Customer Service before you enroll in a clinical trial. We can help you verify that the clinical trial is a qualified clinical trial.

Contraceptive Management and Sterilization

Consultations

You pay a $30 copay for each visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.
Sterilization Procedures

Outpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Injectable, Implantable and Emergency Contraceptives

When you use a network provider, the services shown below are each subject to a $30 copay for each visit in an office setting. However, no more than one copay will be charged for all services that require a copay that are done in a single visit. Services subject to the copay are:

- Injectable contraceptives
- Implantable contraceptives (including hormonal implants)
- Emergency contraception methods (oral or injectable) when furnished by your health care provider

Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If the above contraceptive management or sterilization services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Prescription Contraceptives Dispensed By A Pharmacy

Prescription contraceptives (including emergency contraception) and prescription barrier devices, such as diaphragms and cervical caps, dispensed by a licensed pharmacy are covered on the same basis as any other covered prescription drug. Please see the Prescription Drugs benefit.

The Contraceptive Management and Sterilization benefit doesn’t cover:

- Non-prescription contraceptive drugs, supplies or devices
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Dental Services

This benefit will only be provided for the dental services listed below.

Care For Injuries

Professional Visits

The professional visit copay applies to dentist visits to examine the damage done by a dental injury and recommend treatment. You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Dental Treatment

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If the above services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll
pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

When services are related to an injury, benefits are provided for the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider’s license
- Not required due to damage from biting or chewing
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. “Functionally sound” means that the affected teeth don’t have:
  - Extensive restoration, veneers, crowns or splints
  - Periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury

**Please Note:** An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can’t be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date.

**When Your Condition Requires Hospital Or Ambulatory Surgical Center Care**

**Inpatient Facility Services**

You pay a $250 copay for each inpatient admission when you use a network facility.

**Ambulatory Surgical Center Services**

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

If services and supplies are furnished by a non-network ambulatory surgical center or hospital, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

**Anesthesiologist Services**

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

If anesthesiologist services are provided by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

General anesthesia and related hospital or ambulatory surgical center services for dental procedures are covered when medically necessary for 1 of 2 reasons:

- The member is under the age of 19 or is disabled physically or developmentally and has a dental condition that can’t be safely and effectively treated in a dental office
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren’t done in a hospital or ambulatory surgical center

**Please Note:** This benefit will not cover the dentist’s services unless the services are to treat a dental injury and meet the requirements described above.

**Diagnostic Services**

When you use a network provider, benefits for diagnostic laboratory and imaging services aren’t subject to your calendar year deductible, if any. Benefits are subject to your coinsurance, if any. However, diagnostic surgeries, including scope insertion procedures, such as endoscopies, can only be covered under the *Surgical Services* benefit.
If you see a non-network provider, benefits for diagnostic services are subject to your calendar year deductible, if any, and coinsurance, if any. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits are provided for diagnostic services, including administration and interpretation. Some examples of what’s covered are:

- Diagnostic imaging and scans (including x-rays and EKGs)
- Screening tests for prostate and cervical cancer.
- Colon cancer screening. Includes exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Coverage for colonoscopy and sigmoidoscopy includes medically necessary sedation. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.
- Services that are medically necessary to diagnose infertility or that are part of treatment for the cause of infertility.
- Laboratory services, including routine and preventive
- Pathology tests

In addition to What's Not Covered? this Diagnostic Services benefit doesn't cover:

- Allergy testing. See the Professional Visits And Services benefit for coverage of allergy testing.
- Covered inpatient diagnostic services that are furnished and billed by an inpatient facility. These services are only eligible for coverage under the applicable inpatient facility benefit.
- Outpatient diagnostic services that are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services. Benefits are provided under the Hospital Outpatient Care or Emergency Room Services benefits.
- Mammography services. Please see the Diagnostic And Screening Mammography benefit.

Diagnostic and Screening Mammography

When you see a network provider, benefits for these services aren’t subject to your calendar year deductible, if any. Benefits are subject to your coinsurance, if any, when you use a network provider.

Please Note: If you see a non-network provider, benefits for diagnostic and screening mammography are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

The Diagnostic And Screening Mammography benefit covers diagnostic and screening mammography recommended by your physician, advanced registered nurse practitioner or physician’s assistant.

Dialysis

When you have end-stage renal disease (ESRD) you may be eligible to enroll in Medicare. If eligible, it is important to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

As soon as you are enrolled in Medicare Part B, Premera Blue Cross will pay your Medicare Part B premiums. Premera Blue Cross will continue to pay these premiums for as long as you are enrolled in this plan and eligible for Medicare due to ESRD.

Medicare has a waiting period, generally the first 90 days after dialysis starts. During this waiting period, benefits are subject to the same calendar year deductible and coinsurance, if any, as you would pay for outpatient services for other covered medical conditions. To find the amounts you are responsible for, please see the What Are My Cost-Shares? section.

After Medicare’s waiting period, the deductible and coinsurance, if any, for dialysis are waived for network and non-network providers.

If the dialysis services are provided by a non-contracted provider and you do not enroll in Medicare, then you will owe the difference between the non-contracted provider's billed charges and the payment we will make for the covered services. See the “Allowable Charge” definition for more information.
Emergency Room Services

You pay a $100 copay per visit to the emergency room. Benefits for these services are also subject to your in-network calendar year deductible and coinsurance.

Please Note: The emergency room copay will be waived if you’re admitted directly to the hospital from the emergency room.

This benefit is provided for emergency room services, including related services and supplies, such as surgical dressings and drugs, furnished by and used while in the emergency room. Also covered under this benefit are medically necessary detoxification services. This benefit covers outpatient diagnostic services when they are billed by the emergency room and are received in combination with other hospital or emergency room services.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

You may get care in the emergency room from non-contracted providers. They can bill you for amounts over this plan's allowable charge. See the definition of “allowable charge” to learn about allowable charges for emergency room care.

Foot Care

This benefit covers medically necessary routine foot care.

You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Benefits for the following services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If you see a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Health Management

These services are provided at 100% of allowable charges and are covered up to the benefit limits specified.

Benefits for health education, diabetes health education and nicotine dependency programs are only provided when the following services are furnished by a network or approved provider or facility. To find out whether the provider you have chosen is approved, please contact our Customer Service department. Non-network providers are also covered when they furnish community wellness classes or programs.

Benefits are provided up to a maximum benefit of $250 per member each calendar year for outpatient health education services. The health education maximum doesn't apply to health education and training to manage diabetes. Benefits are also provided up to a separate maximum benefit of $250 per member each calendar year for community wellness services. This benefit doesn't have a calendar year maximum for outpatient nicotine dependency programs.

Health Education

Benefits are provided for outpatient health education services to manage a covered condition, illness or injury. Examples of covered health education services are asthma education and pain management.

Diabetes Health Education

Benefits are provided for outpatient health education and training services to manage the condition of diabetes.

Community Wellness

Community wellness classes and programs that promote positive health and lifestyle choices that qualify as medical expenses are also covered. You pay for the cost of the class or program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.
Many of our network hospitals offer a variety of community wellness classes and programs.

**Nicotine Dependency Programs**

Benefits are provided for nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated above in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

Prescription drugs for the treatment of nicotine dependency are also covered under this plan. Please see the *Prescription Drugs* benefit.

**Home-Based Chronic Care**

This benefit is for members who have a number of chronic conditions and complex health needs. It covers evaluation and management by a team of medical providers in your home or assisted living facility. Covered providers include physicians, nurses and physician assistants. They work with your treating physician as needed. When needed, services can also be provided by phone.

You may be charged for items such as x-rays, lab tests, medical equipment and supplies. See the *Diagnostic Services* and *Medical Equipment And Supply* benefits for details.

**Home and Hospice Care**

To be covered, home health and hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (M.D. or D.O.). In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without home health or hospice services.

Benefits are provided, up to the maximums shown below, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a home health agency and hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master’s degree in social work. Also included in this benefit are medical equipment and supplies provided as part of home health care.

**Home Health Care**

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are provided by network providers.

*Please Note:* If you see a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

This benefit provides up to 130 intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit. Home health care provided as an alternative to inpatient hospitalization is not subject to this limit.

**Hospice Care**

The Hospice benefit covers:

- Hospice care for a terminally ill member, for up to 6 months. Benefits may be provided for up to an additional 6 months of care when needed. The initial 6-month period starts on the first day of covered hospice care.

- Palliative care for a member who has a serious or life-threatening condition that is not terminal. Coverage of palliative care can be extended based on the member's specific condition. Coverage includes expanded access to home-based care and care coordination.

Covered services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don’t count toward the 130 intermittent home visit limit shown above under Home Health Care. You pay the same
share of the allowable charge for in-home hospice care as you do for home health care.

- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.

- **Inpatient hospice care** up to a maximum of 30 days. This benefit provides for inpatient services and supplies used while you’re a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.

  You pay a $250 copay for each inpatient admission when you use a network facility.

  **Please Note:** If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

**Insulin and Other Home and Hospice Care Provider Prescribed Drugs**

Prescription drugs and insulin are subject to your calendar year deductible and coinsurance when provided by a network provider.

**Please Note:** If prescription drugs and insulin are furnished and billed by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice.

**This benefit doesn’t cover:**

- 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
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as “Meals on Wheels,” or nutritional guidance

**Hospital Inpatient Care**

You pay a $250 copay for each inpatient admission when you use a network facility.

**Please Note:** If services and supplies are furnished by a non-network hospital, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration
- Medically necessary detoxification services

For inpatient hospital chemical dependency treatment, except as stated above for medically necessary detoxification services, please see the *Chemical Dependency Treatment* benefit.

For inpatient hospital obstetrical care and newborn care, please see the *Obstetrical Care* and *Newborn Care*
benefits.

For benefit information on professional diagnostic services done while at the hospital, see the Diagnostic Services benefit.

This benefit doesn’t cover:

- Hospital admissions for diagnostic purposes only, unless the services can’t be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary.
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition.

Hospital Outpatient Care

Outpatient Surgery Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Other Outpatient Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network outpatient facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

This benefit covers operating rooms, procedure rooms, and recovery rooms. Also covered are services and supplies, such as surgical dressings and drugs, furnished by and used while at the hospital. This benefit covers outpatient diagnostic services only when they are billed by the hospital and received in combination with other outpatient hospital services.

Infusion Therapy

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are furnished by a network provider.

Please Note: When infusion services and supplies are furnished by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

This benefit is provided for professional services, supplies, drugs and solutions required for infusion therapy in an outpatient setting, such as your home. Infusion therapy (also known as “intravenous therapy”) is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

This benefit doesn’t cover over-the-counter drugs, solutions and nutritional supplements.

Mastectomy and Breast Reconstruction Services

Benefits are provided for mastectomy necessary due to disease, illness or injury. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health And Cancer Rights Act of 1998 (WHCRA). For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- All stages of reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient.
If you would like more information on WHCRA benefits, please call SAMPLE or go to www.dol.gov/ebsa/publications/whcra.html.

This benefit is subject to the same cost-shares that apply to other medical and surgical benefits under this plan. Therefore, the following cost-shares apply:

**Inpatient Facility Services**
You pay a $250 copay for each inpatient admission when you use a network facility.

**Inpatient Professional and Surgical Services**
Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

**Outpatient Surgical Facility Services**
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

**Outpatient Professional Visits**
You pay a $30 copay per visit in an office setting when you use a network provider. Please see the *Professional Visit Copay* provision in the *What Are My Benefits?* section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

**Other Outpatient Professional Services**
Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

**Please Note:** If mastectomy or breast reconstruction services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

**Medical Equipment and Supplies**
Benefits for the following services are subject to your calendar year deductible and coinsurance when you use a network provider.

You don’t have to pay these cost-shares when you purchase a breast pump from a network provider as described later in this benefit.

If you see a non-network provider, benefits for medical equipment and supplies are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

Covered medical equipment, prosthetics and supplies (including sales tax for covered items) include:

**Medical and Respiratory Equipment**
Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. The plan may also provide benefits for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, the plan will provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.
Medical Supplies, Orthotics (Other Than Foot Orthotics), and Orthopedic Appliances

Covered services include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, please see the Prescription Drugs benefit.

Please Note: This benefit does not include medical equipment or supplies provided as part of home health care. See the Home And Hospice Care benefit for coverage information.

Prosthetics

Benefits for external prosthetic devices (including fitting expenses) as stated below, are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

Please Note: This benefit does not include prosthetics prescribed or purchased as part of a mastectomy or breast reconstruction. Please see the Mastectomy And Breast Reconstruction Services benefit for coverage information.

Foot Orthotics and Therapeutic Shoes

Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses up to a combined maximum benefit of $300 per member each calendar year. Items prescribed for the treatment of diabetes are not subject to this limit.

Medical Vision Hardware

Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion, keratoconus, progressive high (degenerative) myopia, irregular astigmatism, and aniridia.

Breast Pumps

This benefit covers the purchase of a standard electric breast pumps. Rental of hospital grade breast pumps is also covered when medically necessary. Purchase of hospital-grade pumps is not covered.

Please Note: Breast pumps are covered only when provided by a medical equipment supplier or a provider approved by us. Please see the definition of “provider.”

For further information, please see the Preventive Care benefit.

The Medical Equipment and Supplies benefit doesn't cover:

• Supplies or equipment not primarily intended for medical use
• Special or extra-cost convenience features
• Items such as exercise equipment and weights
• Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
• Over bed tables, elevators, vision aids, and telephone alert systems
• Structural modifications to your home or personal vehicle
• Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
• Penile prostheses
• Eyeglasses or contact lenses for conditions not listed as a covered medical condition, including routine eye care
• Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.
• Over-the-counter orthotic braces, such as knee braces
• Non-wearable defibrillators, trusses and ultrasound nebulizers
- Blood pressure cuffs or monitors (even if prescribed by a physician)
- Compression stockings that do not require a prescription
- Bedwetting alarms

**Medical Foods**

Benefits for medical foods, as defined below, are subject to your calendar year deductible and coinsurance when you use a network provider.

If you use a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

This plan covers medically necessary medical foods used to supplement or replace a member's diet in order to treat inborn errors of metabolism. An example is phenylketonuria (PKU). Coverage includes medically necessary enteral formula prescribed by a physician or other provider to treat eosinophilic gastrointestinal associated disorder or other severe malabsorption disorder. Benefits are provided for all delivery methods.

Medical foods are formulated to be consumed or administered enterally under strict medical supervision. These foods generally provide most of a person’s nutrition. Medical foods are designed to treat a specific problem that can be diagnosed by medical tests.

This benefit does not cover other oral nutrition or supplements not used to treat inborn errors of metabolism, even if a physician prescribes them. This includes specialized infant formulas and lactose-free foods.

**Mental Health Care**

Benefits for mental health services to manage or lessen the effects of a psychiatric condition are provided as stated below. The *Mental Health Care* benefit does not have its own benefit maximum.

Most benefits are subject to the same calendar year deductible, coinsurance or copays, if any, as you would pay for inpatient services and outpatient visits for other covered medical conditions. To find the amounts you are responsible for, please see the *What Are My Cost-Shares?* section. As the result of applying the federal parity tests, your cost-shares for outpatient facility care for psychiatric conditions will match the cost share for non-preventive screening services shown in the *Diagnostic Services* benefit.

Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice.

Covered mental health services are:

- Inpatient care
- Outpatient therapeutic visits. "Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the *Current Procedural Terminology* manual, published by the American Medical Association.
- Treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
- Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders.
- Applied behavioral analysis (ABA) therapy for members with one of the following:
  - Autistic disorder
  - Autism spectrum disorder
  - Asperger's disorder
  - Childhood disintegrative disorder
  - Pervasive developmental disorder
  - Rett's disorder

Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all
ABA services for a member may be managed by a BCBA or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques. ABA therapy must be provided by:

- A licensed physician (M.D. or D.O.) 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 (Ph.D.)
- A licensed community mental health agency or behavioral health agency that is also state-certified to provide ABA therapy.
- A Board-Certified Behavior Analyst (BCBA). This means a provider who is state-licensed if the State licenses behavior analysts (Washington does). If the state does not require a license, the provider must be certified by the Behavior Analyst Certification Board. 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.

Mental health services other than ABA therapy must be furnished by one of the following types of providers to be covered:

- Hospital
- Washington state-licensed community mental health agency
- Licensed physician (M.D. or D.O.)
- Licensed psychologist (Ph.D.)
- A state hospital operated and maintained by the state of Washington for the care of the mentally ill
- Any other provider listed under the definition of “provider” (please see the Definitions section in this booklet) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license.

When medically appropriate, services may be provided in your home.

For psychological and neuropsychological testing and evaluation benefit information, please see the Psychological and Neuropsychological Testing benefit.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

For prescription drug benefit information, please see the Prescription Drugs benefit.

The Mental Health Care benefit doesn’t cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Outward bound, wilderness, camping or tall ship programs or activities
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluation, forensic evaluations, vocational, educational or academic placement evaluations.

Neurodevelopmental Therapy

Benefits are provided for the treatment of neurodevelopmental disabilities. The following inpatient and outpatient neurodevelopmental therapy services must be medically necessary to restore and improve function, or to maintain function where significant physical deterioration would occur without the therapy. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

Physical, speech and occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders, are covered under the Mental Health Care benefit.

Inpatient Care Benefits for inpatient facility and professional care are provided up to 30 days per member each calendar year. Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility
that meets our clinical standards, and will only be covered when services can’t be done in a less intensive setting.

Inpatient Facility Care
You pay a $250 copay for each inpatient admission when you use a network facility.

Inpatient Professional Services
Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for inpatient care are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Outpatient Care Benefits for outpatient care are subject to all of the following provisions:

• The member must not be confined in a hospital or other medical facility
• Services must be furnished and billed by a hospital, rehabilitation facility that meets our clinical standards, physician, physical, occupational or speech therapist, chiropractor, massage practitioner or naturopath

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, up to a maximum benefit of 15 visits per member each calendar year.

Outpatient Facility Care
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Services
You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for outpatient care are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

A “visit” is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

The plan won’t provide this benefit and the Rehabilitation Therapy benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available.

This benefit doesn’t cover:
• Recreational, vocational, or educational therapy; exercise or maintenance-level programs
• Social or cultural therapy
• Treatment that isn’t actively engaged in by the ill, injured or impaired member
• Gym or swim therapy
• Custodial care

Newborn Care
Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To continue benefits beyond the 3-week period, please see the dependent eligibility and enrollment guidelines outlined in the Who Is Eligible For Coverage? and When Does Coverage Begin? sections.

If the mother isn’t eligible to receive obstetrical care benefits under this plan, the newborn isn’t automatically covered for the first 3 weeks. For newborn enrollment information, please see the Who Is Eligible For...

Plan benefits and provisions will apply, subject to the child’s own applicable copay, calendar year deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

You pay a $250 copay for each inpatient admission when you use a network facility.

Please Note: If the newborn is admitted to a non-network medical facility, benefits for inpatient facility services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

The Newborn Care benefit covers hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury.

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, this restriction doesn’t apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother. In any case, plans and issuers also may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

Professional Care

Benefits for services received in a provider’s office are subject to the terms of the Professional Visits And Services benefit. Well-baby exams in the provider’s office are covered under the Preventive Care benefit, if this plan includes one. When included, a description of the Preventive Care benefit will appear in the Special Benefits section later in this booklet. This benefit covers:

- Inpatient newborn care, including newborn exams
- Follow-up care consistent with accepted medical practice that’s ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision

Inpatient Professional Care

Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Outpatient Professional Visits

You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

If you use a non-network provider, benefits for professional services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician’s assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

This benefit doesn’t cover immunizations and outpatient well-baby exams. See the Preventive Care benefit, if this plan includes one, for coverage of immunizations and outpatient well-baby exams. When included, a description of the Preventive Care benefit will appear in the Special Benefits section later in this booklet.
Nutritional Therapy

You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider in another outpatient setting, benefits are subject to your calendar year deductible and coinsurance.

If you see a non-network provider, nutritional therapy benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. Nutritional therapy for conditions other than diabetes or eating disorders is limited to 4 visits per member each calendar year. Nutritional therapy for the condition of diabetes or for eating disorders isn’t subject to a calendar year benefit limit.

Obstetrical Care

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for all female members.

The Obstetrical Care benefit includes coverage for abortion.

Facility Care

Inpatient Hospital Services

You pay a $250 copay for each inpatient admission when you use a network facility.

Birthing Center and Short-Stay Hospital Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

If you receive inpatient or outpatient care in a non-network medical facility, facility care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

This benefit covers inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

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, this restriction doesn’t apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother. In any case, plans and issuers also may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

Plan benefits are also provided for medically necessary supplies related to home births.

Professional Care

Benefits for the following obstetrical care services are subject to your calendar year deductible and coinsurance when provided by a network provider.

If you see a non-network provider, the following professional care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

• Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
• Delivery, including cesarean section, in a medical facility, or delivery in the home
• Postpartum care consistent with accepted medical practice that’s ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health
agency and/or registered nurse.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician’s assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. Please see the Surgical Services benefit for details on surgery coverage.

Professional Visits And Services

Outpatient Professional Exams and Visits
You pay a $30 copay per visit in an office or home setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside of an office or home setting, benefits are subject to your calendar year deductible and coinsurance.

Other Professional Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If you see a non-network provider, professional benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home. Benefits are also provided for the following professional services when provided by a qualified provider:

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see Definitions)
- Repair of a dependent child’s congenital anomaly
- Consultations and treatment for nicotine dependency
- Consultations with a pharmacist

Therapeutic Injections And Allergy Tests
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

If therapeutic injections, allergy injections and allergy testing are furnished by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits are available for the following:

- Therapeutic injections, including allergy injections
- Allergy testing

Your calendar year deductible and coinsurance, if any, may apply to other services you get during a visit. This includes services such as x-rays, lab work, facility fees and office surgeries.

For surgical procedures performed in a provider’s office, surgical suite or other facility benefit information, please see the Surgical Services benefit.

For professional diagnostic services benefit information, please see the Diagnostic Services benefit.

For home health or hospice care benefit information, please see the Home And Hospice Care benefit.

For diagnosis and treatment of psychiatric conditions benefit information, please see the Mental Health Care benefit.
For diagnosis and treatment of temporomandibular joint (TMJ) disorders benefit information, please see the
*Temporomandibular Joint (TMJ) Disorders* benefit.

**The Professional Visits and Services benefit doesn’t cover:**
- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services

**Psychological and Neuropsychological Testing**

The following services are subject to your calendar year deductible and coinsurance when you use a network provider.

**Please Note:** If you see a non-network provider, benefits for psychological and neuropsychological testing are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the *Rehabilitation Therapy* benefit.

See the *Neurodevelopmental Therapy* benefit for physical, speech or occupational therapy assessments and evaluations related to neurodevelopmental disabilities.

**Rehabilitation Therapy**

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Please see the *Neurodevelopmental Therapy* benefit earlier in this section for coverage of disorders caused by neurological congenital anomalies.

**Inpatient Care** Benefits for inpatient facility and professional care are available up to 30 days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility that meets our clinical standards, and will only be covered when services can’t be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

**Inpatient Facility Care**

You pay a $250 copay for each inpatient admission when you use a network facility.

**Inpatient Professional Services**

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

If services and supplies are furnished by a non-network provider or medical facility, rehabilitation inpatient care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

**Outpatient Care** Benefits for outpatient care are subject to all of the following provisions:
- You must not be confined in a hospital or other medical facility
- Services must be furnished and billed by a hospital, rehabilitation facility that meets our clinical standards, physician, physical, occupational, or speech therapist, chiropractor, massage practitioner or naturopath.

When the above criteria are met, benefits will be provided for physical, speech, and occupational therapy services, including chronic pain care and cardiac and pulmonary rehabilitation programs, up to a combined
maximum benefit of 15 visits per member each calendar year.

Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

**Outpatient Facility Care**

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

**Outpatient Professional Services**

You pay a $30 copay per visit in an office setting when you use a network provider. Please see the *Professional Visit Copay* provision in the *What Are My Benefits?* section of this booklet for details about this copay.

When rehabilitation therapy isn’t provided in an office setting, benefits are subject to your calendar year deductible and coinsurance.

If services and supplies are furnished by a non-network provider or medical facility, rehabilitation outpatient care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

A “visit” is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Massage therapy provided by a licensed massage therapist must be prescribed by a physician.

**The Rehabilitation Therapy benefit doesn’t cover:**

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn’t actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member’s injury or illness or from the date of the member’s surgery that made the rehabilitation necessary

The plan won’t provide the Rehabilitation Therapy benefit and the Neurodevelopmental Therapy benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available.

**Skilled Nursing Facility Services**

You pay a $250 copay for each inpatient admission when you use a network facility.

If you’re admitted to a non-network medical facility, benefits for facility services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the *What Are My Benefits?* section of this booklet.

This benefit is only provided when you’re at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you’re confined in the skilled nursing facility.

Benefits are provided up to 90 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility.

**This benefit doesn’t cover:**

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

**Spinal and Other Manipulations**

You pay a $30 copay per visit in a home or office setting when you use a network provider. Please see the
Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

If you see a network provider outside an office setting, benefits for spinal and other manipulations are subject to your calendar year deductible and coinsurance.

If you see a non-network provider, benefits for spinal and other manipulations are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition. Benefits are limited to 24 visits per member per calendar year.

Non-manipulation services (including diagnostic imaging) are covered as any other medical service.

Available benefits for covered massage and physical therapy services are provided under the Rehabilitation Therapy and Neurodevelopmental Therapy benefits.

Surgical Services

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

If you use a non-network provider, benefits for surgical services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

This benefit covers surgical services (including injections) that are not named as covered under other benefits, when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider’s office. Also covered under this benefit are:

- Anesthesia or sedation and postoperative care as medically necessary. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.
- Cornea transplantation, skin grafts, repair of a dependent child’s congenital anomaly, and the transfusion of blood or blood derivatives.
- Colonoscopy and other scope insertion procedures are also covered under this benefit.
- Surgery that is medically necessary to correct the cause of infertility. This does not include assisted reproduction techniques or sterilization reversal.
- Repair of a defect that is the direct result of an injury, providing such repair is started within 12 months of the date of the injury.
- Correction of functional disorders upon our review and approval.

For organ, bone marrow or stem cell transplant procedure benefit information, please see the Transplants benefit.

For services to change gender, please see the Transgender Services benefit.

This benefit does not cover removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss.

Telehealth Virtual Care Services

Your plan covers access to care via online and telephonic methods when medically appropriate.

Benefits for telehealth are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.

Your provider may provide these services or you may use our preferred telehealth provider. See the back cover for contact information for the preferred telehealth provider.

Temporomandibular Joint (TMJ) Disorders

Inpatient Facility Services

You pay a $250 copay for each inpatient admission when you use a network facility.
Inpatient Professional and Surgical Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Outpatient Surgical Facility Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Visits
You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Outpatient Professional Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you see a network provider.

If services and supplies are furnished by a non-network provider or medical facility, benefits for temporomandibular joint (TMJ) disorders are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. Treatment of TMJ disorders is not covered under other benefits of this plan.

This benefit includes coverage for inpatient and outpatient facility and professional care, including professional visits.

Medical and dental services and supplies 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 or dental practice
• Not experimental or investigational according to the criteria stated under “Definitions,” or primarily for cosmetic purposes

Transgender Services
This benefit covers medically necessary services to change the gender you were born with.

Inpatient Facility Services
You pay a $250 copay for each inpatient admission when you use a network facility.

Inpatient Professional and Surgical Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Outpatient Surgical Facility Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Visits
You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.
When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

**Other Outpatient Professional Services**

Benefits for these services are subject to your calendar year deductible and coinsurance when you see a network provider.

If services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the **What Are My Benefits?** section of this booklet.

This benefit covers services which meet the standards in our medical policy. Call Customer Service or visit our website at [www.premera.com](http://www.premera.com) for the policy.

See the **Surgical Services** benefit for gynecological, urologic and genital surgery for covered conditions other than gender identity disorder or gender dysphoria.

See the **Prescription Drugs** benefit for coverage of prescription drugs associated with transgender procedures.

See the **Mental Health Care** benefit for coverage of mental health services.

This benefit does not cover:

- Transgender surgery for members under 18
- Cosmetic procedures that are not medically necessary to make the gender change. Examples are hair removal and procedures to change the voice.
- Surgery to change the appearance of prior gender change procedures except when medically necessary to correct medical complications.

**Transplants**

**Waiting Period**

This plan doesn’t provide benefits for an organ, bone marrow or stem cell transplant, including any procedure associated with the transplant (for example, testing, blood typing, chemotherapy, radiation or hospitalization) for the first 6 consecutive months after your effective date. However, the transplant waiting period doesn’t apply if the transplant is needed as a direct result of:

- A congenital anomaly of a child who’s been covered through us since birth
- A congenital anomaly of a child who’s been covered through us since placement for adoption with the subscriber

This waiting period may be reduced as explained below.

**How the Waiting Period Can Be Shortened or Waived**

The waiting period for transplants may be reduced by periods of “creditable” coverage you’ve accrued under other health care plans prior to your “enrollment date” (see **Definitions**) for this plan. Most medical health care coverage is considered creditable (see list below).

You’ll receive credit for prior creditable coverage that occurred without a break in coverage of more than 3 months. Any coverage you had before a break in coverage which exceeds 3 months won’t be credited toward your waiting period. Eligibility waiting periods (see **Definitions**) won’t be considered creditable coverage or a break in coverage.

“Creditable” coverage shall mean coverage under one or more of the following types of health care coverage:

- Group health coverage (including self-funded plans and COBRA)
- Individual health coverage
- Part A or B of Medicare
- Medicaid
- Military health coverage
- Indian Health Service or tribal coverage
- State high risk pool
Federal or any public health care plan, including state children’s health care plans
Peace Corps Plan
Government health coverage provided for citizens or residents of a foreign country
Any other health insurance coverage

“Creditable” coverage doesn’t include coverage under a limited policy such as an accident only coverage; disability income insurance; workers’ compensation; limited scope dental or vision plans; liability insurance; automobile medical insurance; specified disease coverage; Medicare supplemental policy; or long-term care policy.

Covered Transplants
The Transplants benefit is not subject to a separate benefit maximum other than the maximum for travel and lodging described below. This benefit covers medical services only if provided by network providers or “Approved Transplant Centers.” Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Inpatient Facility Services
You pay a $250 copay for each inpatient admission to a network facility or an approved transplant center.

Inpatient Professional and Surgical Services
Benefits for a network provider or an approved transplant provider are subject to your in-network calendar year deductible and coinsurance.

Outpatient Surgical Facility Services
Benefits for a network facility or an approved transplant center are subject to your in-network calendar year deductible and coinsurance.

Outpatient Professional Visits
You pay a $30 copay per visit in an office setting to a network provider or an approved transplant provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When a professional visit isn’t provided in an office setting, benefits are subject to your in-network calendar year deductible and coinsurance.

Other Outpatient Professional Services
Benefits for a network provider or an approved transplant provider are subject to your in-network calendar year deductible and coinsurance.

Travel and Lodging
The travel and lodging benefits are subject to your in-network calendar year deductible, but aren’t subject to your in-network coinsurance. Benefits are provided up to the benefit limit of $7,500 per transplant.

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Please see the Definitions section in this booklet for the definition of “experimental/investigational services.”) We reserve the right to base coverage on all of the following:

• Organ transplants and bone marrow/stem cell reinfusion procedures must meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:

• Heart
• Heart/double lung
• Single lung
• Double lung
• Liver
• Kidney
• Pancreas
• Pancreas with kidney
• Bone marrow (autologous and allogeneic)
• Stem cell (autologous and allogeneic)

Please Note: For the purposes of this plan, the term “transplant” doesn’t include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (please see the Surgical Services benefit).

• You’ve satisfied your waiting period.
• Your medical condition must meet our written standards.
• The transplant or reinfusion must be furnished in an approved transplant center. (An “approved transplant center” is a hospital or other provider that’s developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and meets the other approval standards we use.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we’ll direct you to an approved transplant center that we’ve contracted with for transplant services.

Of course, if none of our centers or the approved transplant centers can provide the type of transplant you need, this benefit will cover a transplant center that meets the written approval standards we follow.

Recipient Costs
This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs
Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Travel And Lodging
If you are getting a transplant, this benefit covers costs for your travel and lodging. The plan will not pay more than $7,500 for travel and lodging per transplant. You must live more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require you to stay closer to the transplant center. The plan covers travel and lodging up to the limits set by the IRS for the date you had the expense.

• Travel: Travel is covered only between your home and the approved transplant center. Round trip costs for air, train or bus travel (coach class only) are covered. If you travel by car, the plan covers mileage, parking and toll costs.
• Lodging: Hotel or motel or other lodging for stays away from home.
• Companions: Travel and lodging for 1 companion is covered if the companion has to come with the member due to medical necessity or safety. For a child under age 19, the plan will cover one companion automatically. Costs for a second companion are only covered when medically necessary.
• Limits: The plan covers travel and lodging costs up to the IRS limits in place on the date you had the expense. The per day limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be assumed to be tax advice.

Costs Not Covered
• Meals
• Lodging at a family member’s or friend’s home
• Alcohol or tobacco
• Car rental
• Entertainment, such as movies, visits to museums, or mileage for sightseeing
• Costs for people other than you and your covered companion(s)
• Costs for pets or animals, other than service animals
• Personal care items, such as shampoo or a toothbrush
• Tourist items, such as T-shirts, sweatshirts, or toys
• Phone calls

The Transplants benefit doesn’t cover:
• Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under this benefit.
• 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 or stem cell reinfusion that isn’t covered under this benefit, or for a recipient who isn’t a member
• Donor costs for which benefits are available under other group or individual coverage
• Non-human or mechanical organs, unless we determine they aren’t “experimental/investigational services” (please see the Definitions section in this booklet)
• 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

Urgent Care Centers
This plan covers care you get in an urgent care center. Urgent care centers have extended hours and are open to the public. You can go to an urgent care center for an illness or injury that needs treatment right away. Examples are minor sprains, cuts and ear, nose and throat infections. Covered services include the doctor’s services.
• If the urgent care center is not a part of a hospital or is not attached to a hospital:
  You pay a $30 copay per visit when you use a network center. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.
  You may have to pay a separate copay or your deductible and coinsurance for other services you get during a visit to the urgent care center. This includes things like x-rays, lab work, shots and office surgeries. See those covered services for details.
  If you use a non-network urgent care center, you pay your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.
• If the urgent care center is part of a hospital or is located in or attached to hospital, you pay a $100 copay per visit. Benefits for these services are also subject to your in-network calendar year deductible and coinsurance.
  You may also have to pay your in-network calendar year deductible and coinsurance if the center charges facility fees.

SPECIAL BENEFITS
Orthognathic Surgery (Jaw Augmentation Or Reduction)
Inpatient Facility Services
You pay a $250 copay for each inpatient admission when you use a network facility.

Inpatient Professional Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Outpatient Surgical Facility Services
Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.
Outpatient Professional Visits

You pay a $30 copay per visit in an office setting when you use a network provider. Please see the Professional Visit Copay provision in the What Are My Benefits? section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for orthognathic surgery are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) are provided up to a lifetime maximum benefit of $5,000 per member. These procedures are not covered under other benefits of this plan. The only exception to this benefit maximum is treatment needed to repair a dependent child’s congenital anomaly.

Preventive Care

Benefits for preventive exams performed on an outpatient basis, including immunizations, are not subject to a separate benefit maximum. This benefit will be provided only when covered preventive exams and immunizations are furnished by network providers. There is an exception for certain immunizations done at a mass immunizer location as described below.

You pay a $30 copay per visit when you use a network provider. Benefits for immunizations done by a network provider aren’t subject to the professional visit copay.

Covered Services

Exams  The following exam services are covered:
- Routine physical exams
- Well-baby and well-child exams
- Physical exams related to school, sports and employment

Immunizations  Immunizations other than immunizations described below are covered only when furnished by a network provider. Seasonal and travel immunizations and certain other immunizations, such as flu shots, flu mist, pneumonia immunizations, whooping cough and adult shingles immunizations, are covered when done by any pharmacy, the county health department, travel clinic or other mass immunizer location.

The Preventive Care benefit doesn’t cover:
- Services not named above as covered
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
- Routine or other dental care
- Routine vision and hearing exams
- Gym fees or exercise classes or programs
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member. Please see the plan’s non-preventive benefits for available coverage.
- Physical exams for basic life or disability insurance
- Work-related disability or medical disability evaluations
- Preventive laboratory and imaging services, screening and diagnostic mammography. Please see the Diagnostic Services benefit and the Diagnostic And Screening Mammography benefit for available coverage.
- Facility charges. When you get preventive care at a clinic or physician’s office that is based in a hospital, you
must pay hospital cost shares when there are any extra facility charges. See the Hospital Outpatient Care benefit for those costs.}

**Vision Exams**

You pay a $25 copay per visit when you use a network provider. If vision testing is done during the same visit as the routine vision exam, you will pay only one copay.

When you see a non-network provider, vision benefits are subject to your deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

This benefit provides for one routine vision exam per member each calendar year. Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

**Please Note:** For vision exams and testing related to medical conditions of the eye, please see the Professional Visits And Services benefit.

The Vision Exams benefit doesn't cover vision hardware or fitting examinations for contact lenses or eyeglasses.

**Vision Hardware**

Benefits for vision hardware are provided when all of the requirements listed below are met:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be named in this benefit as covered
- They must not be excluded from coverage under this plan

Benefits for the following vision hardware and related services are provided at 100% of allowable charges, up to a maximum benefit of up to $150 per member per calendar year.

**What's Covered:**

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Vision hardware benefits are based on the “allowable charge” (please see the Definitions section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what’s covered under this benefit aren’t covered under other benefits of this plan.

**Please Note:** Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don’t apply to vision hardware benefits.

The Vision Hardware benefit doesn't cover:

- Services or supplies that aren’t named above as covered, or that are covered under other provisions of this plan. Please see the Medical Equipment And Supplies benefit for hardware coverage for certain conditions of the eye.
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying
attachments) or light-sensitive lenses, even if prescribed

- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
  - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

**Prescription Drugs**

The **Prescription Drugs** benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered under this benefit are injectable supplies. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: “Caution: Federal law prohibits dispensing without a prescription.” In no case will the member’s out-of-pocket expense exceed the cost of the drug or supply.

The **Prescription Drugs** benefit requires you to pay either a copay or coinsurance for each separate new prescription or refill you get from participating pharmacies. The copay amounts and/or coinsurance percentages are shown below. A “copay” is a fixed up-front dollar amount that you’re required to pay to the retail pharmacy or the participating mail-order pharmacy for each prescription drug purchase. “Coinsurance” is the percentage of the allowable charge that you’re required to pay to the pharmacy for each prescription drug purchase.

See “Retail Pharmacy Prescriptions” later in this benefit for the additional amounts you would pay if you went to a non-participating retail pharmacy.

**Please Note:** Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don’t apply to this benefit. Copays and coinsurance required under this benefit don’t apply to other benefits of this plan.

**Retail Pharmacy Prescriptions**

Generic Drugs ............................................ $10 copay  
Brand Name Drugs .................................... $30 copay

**Dispensing Limit**

Benefits are provided for up to a 30-day supply of covered medication. See question 6 of **Questions And Answers About Your Pharmacy Benefits** for exceptions to the supply limits shown above.

**How To Use The Retail Pharmacy Benefit**

- **Participating Retail Pharmacies** After you’ve paid any required cost-share, the plan will pay the participating pharmacy directly.

  To avoid paying the retail cost for a prescription drug that’s reimbursable at a lower allowable charge rate, be sure to present your identification card to the pharmacist for all prescription drug purchases.

- **Non-Participating Retail Pharmacies** You pay the full price for the drugs and submit a claim for reimbursement. Please see the **How Do I File A Claim?** section in this booklet for more information.

After you’ve paid any required cost-share, you pay 40% of the allowable charge for the prescription or refill and the difference between the pharmacy’s billed charge and the allowable charge. This benefit applies to all prescriptions filled by a non-participating retail pharmacy, including those mailed or delivered to you.

If you need a list of participating pharmacies, please call us (see the back cover of this booklet). You can also call the toll-free Pharmacy Locator Line; this number is located on the back of your Premera Blue Cross ID card.

**Mail-Order Pharmacy Program**

Generic Drugs ............................................ $25 copay  
Brand Name Drugs .................................... $75 copay
Dispensing Limit

Benefits are provided up to a 90-day supply of covered medication. See question 6 of Questions And Answers About Your Pharmacy Benefits for exceptions to the supply limits shown above.

How To Use The Mail-Order Pharmacy Program

You can often save time and money by filling your prescriptions through the mail-order pharmacy program. After you’ve paid any required cost-share, the plan will pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by our participating mail-order pharmacy.

Ask your physician to prescribe needed medications for up to the maximum dispensing limit stated earlier in this benefit, plus refills. If you’re presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a refill prescription to the mail-order pharmacy. Please see the How Do I File A Claim? section in this booklet for more information on submitting claims.

To obtain additional details about the mail-order pharmacy program, you may call our Customer Service department. You may also call the Pharmacy Benefit Administrator’s Customer Service department or visit their Web site. You’ll find the phone numbers and the Web address on the back cover of this booklet.

Specialty Pharmacy Program

Specialty drugs are subject to the cost shares specified above under “Retail Pharmacy Prescriptions.” These drugs are limited to a 30-day supply.

“Specialty drugs” are drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis or growth disorders (excluding idiopathic short stature without growth hormone deficiency).

Specialty pharmacies are pharmacies that focus on the delivery and clinical management of specialty drugs. You and your health care provider must work with a network specialty pharmacy to arrange ordering and delivery of these drugs. See How Does Selecting A Provider Affect My Benefits? for details about the provider networks.

Please note: This plan will only cover specialty drugs that are dispensed by a network specialty pharmacy. Contact Customer Service for details on which drugs are included in the specialty pharmacy program, or visit our Web site, which is shown on the back cover of this booklet.

What’s Covered

This benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan’s definition of “prescription drug” (please see the Definitions section in this booklet).
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Human growth hormone 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. It is not covered under other benefits of this plan.
- Prescription drugs for the treatment of nicotine dependency.
- Drugs for fertility treatment or assisted reproduction procedures. The limitations of the Assisted Reproduction benefit apply.
- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps)
Oral Chemotherapy Medication
This benefit covers self-administered oral medication that can be used to kill cancerous cells or slow their growth when the medication is dispensed by a pharmacy. When medically necessary for all covered health conditions, these drugs are covered at 100% of the allowable charge. You pay no deductible, copay or coinsurance.

Diabetic Injectable Supplies And Drugs
When needles and syringes are purchased along with a diabetic drug, only the cost-share for the diabetic drug will apply.

When needles and syringes are purchased separately from the diabetic drug, the Brand Name Drug cost-share will apply for each item purchased.

The Brand Name Drug cost-share will apply to purchases for alcohol swabs, test strips, testing agents and lancets. If any prescriptions require a copay, a separate copay would apply to each item purchased.

Exclusions
This benefit doesn’t cover:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but aren’t limited to non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Non-participating mail-order pharmacies
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Blood or blood derivatives. See the Blood Products and Services benefit for coverage.
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider’s original order
- Drugs dispensed for use or administration in a health care facility or provider’s office, or take-home drugs dispensed and billed by a medical facility. The exceptions are for prescription drugs provided as part of the plan's Specialty Pharmacy provision (see Specialty Pharmacy Program earlier in this benefit), which are payable under this benefit, regardless of where they are administered.
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is self-administered injectable diabetic drugs.) Please see the Infusion Therapy benefit.
- Drugs to treat sexual dysfunction
- Weight management drugs
- Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered ‘in this benefit). Please see the Medical Equipment And Supplies benefit for available coverage.
- Immunization agents and vaccines, except as stated in the Preventive Care benefit, if the plan includes one. When included, a description of the Preventive Care benefit will appear in this Special Benefits of your booklet.

Tablet Splitting Program
The Tablet Splitting Program lets you pay less for some prescription drugs. The drugs chosen for the program are safe to split without risking quality or effectiveness.

Call Customer Service to find out which drugs are in the tablet splitting program. If you take any of those drugs, you can choose whether or not to sign up. When you sign up, the drug is dispensed at double strength. Then you split each tablet in half and take 1 half at a time. We give you the tablet splitter.

When you take part in the program, you will pay half the copay amount shown above in this benefit for a drug...
included in the program. If you pay coinsurance for those drugs, the percentage you pay will stay the same, but you will have lower out-of-pocket costs because the double strength tablets are cheaper than the single-strength tablets.

Because you will split the tablets, they will be dispensed at half the normal supply limit shown in Dispensing Limits above.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered under your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact us (the health carrier) at the Customer Service phone number shown on the back cover of this booklet or visit our website at www.premera.com. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington State Department of Health at 360-236-4700 www.doh.wa.gov, or HSQACS@doh.wa.gov.

Questions and Answers About Your Pharmacy Benefits

1. Does this plan exclude certain drugs my health care provider may prescribe, or encourage substitution for some drugs?

Your coverage for drugs is not restricted to drugs on a specific list. This plan does make use of a list of drugs, sometimes called a “formulary.”

Our Pharmacy and Therapeutics Committee makes the decisions about the drug list. This committee includes doctors and pharmacists from the community. The committee reviews medical studies, scientific articles and papers and other information on drugs and their uses to choose safe and effective drugs for the list.

This plan does cover drugs that are not on the drug list on the same basis as drugs that are. However, this plan doesn’t cover certain categories of drugs. These are listed under Exclusions earlier in this benefit.

Certain drugs need prior authorization. As part of this review, some prescriptions may require more medical information from the prescribing provider or substitution of equivalent medication. Please see Prior Authorization in the Care Management section of your booklet for more detail.

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 brand name cost-share. See above in this benefit for the amount you pay. 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 brand name cost-share. Please ask your pharmacist about the higher cost 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 substitution does not apply 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 shown above in this benefit. If your request is not approved, you will pay the penalty described under Generic Drug Substitution above.

Exception Process The request can be made in writing, electronically or by phone. Your provider must give us a written or oral statement that confirms the need for the requested drug to treat your condition and states that the criteria above are met. We have the right to ask for medical records that relate to the request.
Within 5 calendar days after we get the information we need from your provider, we will let you or your provider know in writing if your request is approved.

**If Your Request Is Urgent** We will respond to your request within 48 hours after we get the information we need from your provider if 1 of the following is true:

- Your health problem may put your life or health in serious danger.
- You have already started taking the drug.

The provider must confirm that 1 of the 2 situations above is true. The provider must also explain the harm that would come to you if we did not respond to the request within 48 hours.

In no case will your out-of-pocket expense exceed the cost of the drug.

2. **When can my plan change the pharmacy drug list? If a change occurs, will I have to pay more to use a drug I had been using?**

   Our Pharmacy and Therapeutics Committee reviews the pharmacy drug list frequently throughout the year. It may make changes to the list at any point if new drugs appear on the market.

   Changes to our drug list do not change your benefits, unless a generic equivalent to a brand name drug becomes allowed by law. See question 1 for changes to your share of the cost of the brand name drug if this occurs. The amount you pay is based on whether the drug is a generic or brand drug on the date it is dispensed. Whether the pharmacy is in the network or not on the date the drug is dispensed is also a factor.

3. **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. The plan's rules about substitution of generic drugs are described above in question 1.

   You can appeal any decision you disagree with. Please see the **Complaints And Appeals** section in this booklet, or call our Customer Service department at the telephone numbers listed on the back cover of this booklet for information on how to initiate an appeal.

4. **How much do I have to pay to get a prescription filled?**

   The amount you pay for covered drugs dispensed by a retail pharmacy or through the mail-order pharmacy benefit is described above.

5. **Do I have to use certain pharmacies to pay the least out of my own pocket under this plan?**

   Yes. You receive the highest level of benefits when you have your prescriptions filled by participating pharmacies. The majority of retail pharmacies in Washington are part of our pharmacy network. Your benefit covers prescription drugs dispensed from a non-participating pharmacy, but at a higher out-of-pocket cost to you as explained above.

   Our mail order program offers lower cost-shares and lets you buy larger supplies of your medications, but you must use our participating mail order pharmacy.

   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 Premera Blue Cross ID card.

   Also see **Specialty Pharmacy Program** earlier in this benefit for information on participating specialty pharmacies.

6. **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** provisions above.

   Benefits for refills will be provided only when the member has used 75% of a supply of a single medication. The 75% 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. This rule does not apply when the member has purchased more than a 180-day supply of birth control drugs at one time.
Exceptions to the supply limit are allowed as required by law:

- A pharmacist can approve an early refill of a prescription for eye drops or eye ointment in some cases. If you must pay a copay for the drug, the full copay is required for the early refill.

- A different supply can be allowed so that a new drug can be refilled at the same time as drugs that you are already taking. We will pro-rate the cost-shares to the exact number of days early that the refill is dispensed. For example, a drug with a $10 copay for a 30-day supply would have a per-day copay of 33 cents. If the member needed a 20-day supply of the drug, we would then multiply the 33 cents by 20.

- You can ask for up to a 12-month supply of birth control drugs. If you have a copay for the drug, you must pay one copay for each 30-day supply from a retail pharmacy or one copay for each 90-day supply from the in-network mail-order pharmacy.

The plan can also cover more than the 30-day or 90-day supply limit if the drug maker’s packaging does not let the exact amount be dispensed. If you must pay a copay for the drug, you pay one copay for each 30-day supply from a retail pharmacy or one copay for each 90 day supply from the in-network mail-order pharmacy.

7. 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 pharmacy. Other services, such as consultations with a pharmacist, diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Drug Discount Programs

Premera Blue Cross may receive rebates from its pharmacy benefit manager or other vendors. Such rebates are Premera Blue Cross's property. These rebates are retained by Premera Blue Cross and may be taken into account in setting subscription charges or may be credited to administrative charges and are not reflected in your allowed amount. The allowed amount is not adjusted to reflect rebates received as part of Drug Discount Programs.

In addition, the allowed amount that your payment for drugs is based on may be higher than the price Premera Blue Cross pays its pharmacy benefit manager or other vendors for those drugs. The difference constitutes Premera Blue Cross property. Premera Blue Cross is entitled to retain and shall retain the difference and may apply it to the cost of Premera Blue Cross's operations. If your drug benefit includes a copay, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowed amount. The allowed amount is not adjusted to reflect discounts received as part of Drug Discount Programs.

Routine Hearing Exams

You pay a $30 copay per visit when you use a network provider for routine hearing exams. If hearing testing is done in a separate visit, the office visit copay does not apply to the visit for testing.

If you see a non-network provider, benefits for routine hearing exams are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the What Are My Benefits? section of this booklet.

Benefits are provided for one routine hearing examination (or screening) per member every 2 consecutive calendar years.

Hearing exam services include:

- Examination 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.

The Routine Hearing Exams benefit doesn’t cover hearing hardware or fitting examinations for hearing hardware.

Hearing Hardware

Benefits for hearing hardware are provided up to the maximum benefit of $1,000 per member in a period of 3 consecutive calendar years.
Please Note: Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don’t apply to hearing hardware benefits.

To receive your hearing hardware benefit:
- You must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA) before obtaining hearing aids
- You must purchase a hearing aid device

Benefits are provided for the following:
- Hearing aids (monaural or binaural) prescribed as a result of an exam
- Ear molds
- The hearing aid instruments
- 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 either the prescribing physician or audiologist
- Repairs, servicing, and alteration of hearing aid equipment purchased under this benefit

This benefit doesn’t cover:
- 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.

WHAT DO I DO IF I’M OUTSIDE WASHINGTON AND ALASKA?

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera Blue Cross 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.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues’ network providers. The Host Blue is responsible for its 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). This Out-Of-Area Care section explains how the plan pays both types of providers.

Your getting services through these Inter-Plan Arrangements does not change what the plan covers, benefit levels, or any stated eligibility requirements. Please call us if your care needs 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’ network providers on the lower of:
- The provider’s billed charges for your covered services; or
- The allowable charge that the Host Blue made available to us.

Often, the allowable charge 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.

**Clark County Providers** Services in Clark County, Washington are processed through the BlueCard Program. Some providers in Clark County do have contracts with us. These providers will submit claims directly to us, and benefits will be based on our allowable charge for the covered service or supply.

**Value-Based Programs** You might have a provider that participates in a Host Blue’s value-based program (VBP). Value-based programs focus on meeting standards for treatment outcomes, cost and quality, and for coordinating care when you are seeing more than one provider. The Host Blue may pay VBP providers for meeting the above standards. If the Host Blue includes charges for these payments in the allowable charge for a claim, you would pay a part of these charges if a deductible or coinsurance applies to the claim. If the VBP pays the provider for coordinating your care with other providers, you will not be billed for it.

**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 allowable charge 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 allowable charge for these providers or the pricing requirements under applicable law. Please see the definition of “Allowable Charge” in Definitions in this booklet for details on allowable charges.

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 1-800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.

**More Questions**
If you have questions or need to find out more about the BlueCard Program, please call our Customer Service Department. To find a provider, go to www.premera.com or call 1-800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

**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 to verify that you meet the required criteria for claims payment.

**PRIOR AUTHORIZATION**
Your coverage for some services depends on whether the service is approved through the prior authorization process before you receive it.

A planned service is reviewed to make sure it is medically necessary and eligible for coverage under this plan. We will let you know in writing if the service is authorized. We will also let you know if the services are not
authorized and the reasons why. If you disagree with the decision, you can request an appeal. See *When You Have An Appeal* in your booklet or call us.

There are three situations where prior authorization is required:

- Before you receive certain medical services or prescription drugs
- Before you schedule a planned admission to certain inpatient facilities
- When you want to receive the in-network benefit level for services you receive from a non-network provider.

**How To Ask For Prior Authorization**

The plan has a specific list of services that must have prior authorization with any provider. The list is on our Web site at [www.premera.com](http://www.premera.com). Before you receive services, we suggest that you review this list.

**Services From Network Providers**: It is your network provider’s responsibility to get prior authorization. Your network provider can call us at the number listed on your ID card to request a prior authorization.

**Services From Non-Network Providers**: It is your responsibility to get prior authorization for any services that are on the prior authorization list when you see a non-network provider. You or your provider can call us at the number listed on your ID card to request a prior authorization. However, it is a good idea to call us to make sure the request was approved.

We will respond to a request for prior authorization within 5 calendar days of receipt of all information necessary to make a decision. If your situation is clinically urgent (meaning that your life or health would be put in serious jeopardy if you did not receive treatment right away), you may request an expedited review. Expedited reviews are responded to as soon as possible, but no later than 48 hours after we get all the information necessary to make a decision. We will provide our decision in writing.

Our prior authorizations will be valid for 30 calendar days. This 30-day period is subject to your continued coverage under the plan. If you don't receive the service, drug or item within that time, you will have to ask us for another prior authorization.

**Prior Authorization Penalty**

**For Services From Network Providers**

Network providers will get a prior authorization for you. You should verify with your provider that a prior authorization request has been approved in writing before you receive services.

**For Services From Non-Network Providers**

It is your responsibility to get prior authorization for any services that are on the prior authorization list when you see a non-network provider. *If you do not get prior authorization, but the service is covered by the plan, you will have to pay a penalty.* The penalty is 50 percent of the allowable charge. The maximum penalty is $1,500 per occurrence. You pay this penalty plus any cost-share that your plan requires for the covered services.

The prior authorization penalty does not count toward this plan’s deductible or out-of-pocket maximum, if any.

**Exceptions**

The services below do not need prior authorization. Instead, you must tell us as soon as reasonably possible after you receive them:

- Emergency hospital admissions, including admissions for drug or alcohol detoxification. If you are admitted to a non-network hospital due to a medical emergency, those services are always covered under your in-network cost-share. The plan will continue to cover those services until you are medically stable and can safely transfer to a network hospital. If you choose to remain at the non-network hospital after you are stable to transfer, coverage will revert to the out-of-network benefit. The plan will provide benefits based on the allowable charge. If the hospital is non-network, you may be billed for charges over the allowable charge.

- Childbirth admission to a hospital, or admissions for newborns who need medical care at birth. Admissions to a non-network hospital will be covered at the out-of-network cost-share unless the admission was a medical emergency.

- You may have a second plan that also asks you to get prior authorization for the same service. In that case, this plan will not require prior authorization for that service when two things are true:
• Your other plan is primary to this plan. See Coordinating Benefits With Other Health Care Plans to find out how to tell which plan is primary.
• You complied with the other plan’s prior authorization process.

Prior Authorization For Prescription Drugs
Certain prescription drugs you receive through a pharmacy must have prior authorization before you get them at a pharmacy, in order for the plan to provide benefits. Your provider can ask for a prior authorization by faxing a prior authorization form to us. This form is in the pharmacy section of our Web site at www.premera.com. You will also find the specific list of prescription drugs requiring prior authorization on our Web site. If your prescription drug is on this list, and you do not get prior authorization, when you go to the pharmacy to fill your prescription, your pharmacy will tell you that it needs to be prior authorized. You or your pharmacy should call your provider to let them know. Your provider can fax us a prior authorization form for review.

If Premera Blue Cross or the prescriber cannot be reached at the time a network pharmacy asks for a prior authorization, the plan may cover a small supply of the drug to allow more time for the prior authorization. The cost-shares shown in the Prescription Drug benefit will apply. Network pharmacies will take care of this for you. If an advance 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 allowable charge. See How Do I File A Claim? for details.

Benefits for some prescription drugs may be limited to one or more of the following:
• A set number of days’ supply
• A specific drug or drug dose that is appropriate for a normal course of treatment
• A specific diagnosis
• You may need to get a prescription drug from an appropriate medical specialist
• You may have to try a generic drug or a specified brand name drug first

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.

Prior Authorization For Non-Network Providers
This plan provides benefits for non-emergency services from non-network providers at a lower benefit level. You may receive benefits for these services at the in-network cost-share if the services are medically necessary and only available from a non-network provider. You or your provider may request a prior authorization for the in-network benefit before you see the non-network provider.

The prior authorization request must include the following:
• A statement that the non-network provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from a network provider
• Any necessary medical records supporting the request.

If the request is approved, you pay the in-network cost-share for covered services. However, the allowable charge is still the amount allowed for out-of-network providers. See Definitions.

If the request is denied but the plan does cover the services, you will have to pay the non-network cost-share.

Whether or not your request is approved, you will also have to pay any amounts over the plan's allowable charge for covered services.

CLINICAL REVIEW
Premera Blue Cross has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. Our medical policies are on our Web site. You or your provider may review them at www.premera.com. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain the information, please send your request to Care Management at the address or fax number shown on the back cover.
Premera Blue Cross reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigational. A decision by Premera Blue Cross following this review may be appealed in the manner described in Complaints And Appeals.

In general, when there is more than one treatment option, the plan will cover the least costly option that will meet your medical needs. Premera Blue Cross works cooperatively with you and your physician to consider effective alternatives to hospital stays and other high-cost care to make better use of this plan's benefits.

PERSONAL HEALTH SUPPORT PROGRAMS

The plan offers participation in Premera Blue Cross's personal health support services to help members with such things as managing complex medical conditions, a recent surgery, or admission to a hospital. Services include:

- Helping to overcome barriers to health improvement or following providers’ treatment plan
- Coordinating care services including access
- Helping to understand the health plan’s coverage
- Finding community resources

Participation is voluntary. To learn more about the personal health support programs, contact Customer Service at the phone number listed on the back of your ID card.

WHAT’S NOT COVERED?

This section of your booklet explains circumstances in which all the benefits of this plan are either limited or no benefits are provided. Benefits can also be affected by our Care Management provisions and your eligibility. In addition, some benefits have their own specific limitations.

WAITING PERIOD FOR TRANSPLANTS

Organ, bone marrow and stem cell transplants are subject to a benefit-specific 6-month waiting period. Except as noted in the Transplants benefit, benefits won’t be provided for transplant-related services for the first six months after your effective date.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, the plan won’t provide benefits for the following:

Benefits From Other Sources

This plan does not cover services that are covered by such types of insurance as:

- 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
- Any type of liability insurance, such as home owners' coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits That Have Been Exhausted

Amounts that exceed the allowable charge or maximum benefit for a covered service.

Biofeedback

Biofeedback that is deemed experimental or investigational treatment for the condition (see Definitions). Examples of what is not covered are EEG biofeedback and neurofeedback.

Caffeine Or Nicotine Dependency

Treatment of caffeine dependency; treatment of nicotine dependency except as stated under the Health Management, Professional Visits And Services and Prescription Drugs benefits.

Charges For Records Or Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review.
Cosmetic Services
The plan does not cover services, drugs, or supplies for cosmetic purposes, including any direct or indirect complications and aftereffects. Examples of what is not covered are reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body.

Please see the Surgical Services, Mastectomy And Breast Reconstruction and Transgender Services benefits for more information about what the plan does cover.

Counseling, Educational Or Training Services
- Counseling, education or training services, except as stated under the Chemical Dependency Treatment, Health Management, Nutritional Therapy, Professional Visits And Services and Mental Health Care benefits. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy
- 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 are otherwise should be provided by school staff. This does not apply to training that is directed at the member's significant behavioral difficulties during schoolwork. Please see the Mental Health Care benefit.

Court-Ordered Services
Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except as deemed medically necessary.

Custodial Care
Custodial care, except when provided for hospice care (please see the Home And Hospice Care benefit).

Dental Care
Dental services or supplies, except as specified under the Dental Services or Temporomandibular Joint (TMJ) Disorders benefits. (Please see the Medical Services section under What Are My Benefits? earlier in this booklet.)

Donor Breast Milk

Drugs And Food Supplements
Over-the-counter drugs, solutions, supplies, food and nutritional supplements other than those covered under the Medical Foods benefit; over-the-counter contraceptive drugs, supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that don’t require a prescription. Please see the Prescription Drugs benefit for details.

Environmental Therapy
Therapy designed to provide a changed or controlled environment.

Experimental Or Investigational Services
Any service or supply that Premera Blue Cross determines is experimental or investigational on the date it’s furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of “experimental/investigational services” (please see the Definitions section in this booklet).

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the Complaints And Appeals section in this booklet for an explanation of the appeals process.

Family Members Or Volunteers
- Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate
relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.

- Services or supplies provided by volunteers, except as specified in the Home And Hospice Care benefit

Governmental Medical Facilities

Services and supplies furnished by a governmental medical facility, except when:

- Your request for a benefit level exception for non-emergent care to the facility is approved. (Please see the Prior Authorization provision in this booklet.)
- You're receiving care for a “medical emergency” (please see the Definitions section in this booklet)
- We must provide available benefits for covered services as required by law or regulation

Hair Loss

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth
- Hair prostheses, such as wigs or hair weaves, transplants, and implants

Illegal Acts and Terrorism

This plan does not cover illness or injuries resulting from a member’s commission of:

- A felony (does not apply to a victim of domestic violence)
- An act of terrorism
- An act of riot or revolt

Immunizations

Immunizations, regardless of the reason

Laser Therapy

Low-level laser therapy

Light Therapy for Vitiligo

Military Service and War

This plan does not cover 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. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

No Charge Or You Don’t Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this plan weren’t in effect
- Services for which you don’t legally have to pay, except as required by law in the case of federally qualified health center services

Non-Treatment Facilities, Institutions Or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes, camps and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations. Please see the applicable medical benefit, the Mental Health Care benefit, or the Chemical Dependency Treatment benefit for details.

Not Covered

- Services or supplies ordered when this plan isn’t in effect, or when the person isn’t covered under this plan, except as stated under specific benefits and under Extended Benefits
- Services or supplies provided to someone other than the ill or injured member, other than outpatient health
education services covered under the Health Management benefit. This includes training or educational services to another provider.

- Services and supplies that aren’t listed as covered under this plan
- Services and supplies directly related to any condition, or related to any other service or supply that isn’t covered under this plan

Not In The Written Plan Of Care

Services, supplies or providers not in the written plan of care or treatment plan.

Not Medically Necessary

- Services or supplies that aren’t medically necessary even if they’re court-ordered. This also includes places of service, such as inpatient hospital care.
- Hospital admissions for diagnostic purposes only, unless the services can’t be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition

Orthodontia Services

Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

Outside The Scope Of A Provider’s License Or Certification

Services or supplies that are outside the scope of the provider’s license or certification. Services or supplies that are furnished by a provider that isn’t licensed or certified by the state in which the services or supplies were received, except as allowed for applied behavior analysis providers when the state in which they practice does not license them. See the Mental Health Care benefit.

Personal Comfort Or Convenience Items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges, babysitting
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home And Hospice Care benefit); and transportation services
- Dietary assistance, such as “Meals on Wheels”
- Charges for provider travel 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.
- Arrangements in which the provider lives with the member.

Private Duty Nursing Services

Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family member to provide care. The contract is between the nurse and the family member, and there is no home health agency to provide oversight of the nurse or the work is provided. The care may be skilled, supportive or respite in nature.

Routine Or Preventive Care

- Impression casting for foot prosthetics or appliances and prescriptions thereof. However, foot-support supplies, devices and shoes are covered as stated under the Medical Equipment And Supplies benefit.
- Exams to assess a work-related disability or medical disability
- Services and supplies that aren’t directly related to your illness, injury or distinct physical symptoms. Examples are routine physical examinations and diagnostic surgery. However, this exclusion doesn’t apply to services and supplies specified as covered under the following benefits:
  - Diagnostic Services
• **Diagnostic And Screening Mammography**

• **Newborn Care**

• **Preventive Care**, if included in this plan. When included, a description of the Preventive Care benefit will appear in the Special Benefits section of the booklet.

• **Health Management**

**Serious Adverse Events and Never Events**

Members and this plan are not responsible for payment of services provided by network 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. Network providers may not bill members for these services and members are held harmless.

Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.

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 at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) Web page at [www.cms.hhs.gov](http://www.cms.hhs.gov).

**Sexual Dysfunction**

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

**Vision Therapy**

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment.

**Voluntary Support Groups**

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous; peer-mediated groups or interventions.

**Weight Loss Surgery or Drugs**

Surgery or drugs for weight loss or to manage weight, even if you also have an illness or injury that might be helped by weight loss. Also not covered are any direct or indirect complications, follow-up services, and aftereffects thereof. (An example of an aftereffect that would not be covered is removal of excess skin or fat that came about because of the surgery or drugs.) This exclusion applies to all weight loss surgeries, no matter where you have them. It also applies to all drugs and supplements for weight loss.

**Work-Related Conditions**

Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

• Occupational coverage required of, or voluntarily obtained by, the employer

• State or federal workers’ compensation acts

• Any legislative act providing compensation for work-related illness or injury

However, 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.
WHAT IF I HAVE OTHER COVERAGE?

Please Note: If you participate in a Health Savings Account (HSA) and have other health care coverage that is not a high deductible health plan as defined by IRS regulations, the tax deductibility of the Health Savings Account contributions may not be allowed. Contact your tax advisor or HSA plan administrator for more information.

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

When you have more than one health plan, “coordination of benefits (COB)” makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims with your primary plan first. If you have Medicare, Medicare may submit your claims to your secondary plan. Please see COB's Effect On Benefits below in this section for details on primary and secondary plans.

If you do not know which is your primary plan, you or your provider should contact any of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan(s) to determine which is primary and will let you know within 30 calendar days.

Caution: All health plans have timely filing requirements. If you or your provider fails to submit your claim to your secondary plan within that plan’s claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary plan, you or your provider will need to submit your claim to the secondary plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers any changes in your coverage.

COB Definitions

For the purposes of COB:

• A plan is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB doesn't apply is treated as a separate plan.

• “Plan” means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.

• “Plan” doesn't mean: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.

• This plan means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your Premera Blue Cross plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans’ dental benefits, while medical benefits are coordinated only with other plans’ medical benefits.

• Primary plan is a plan that provides benefits as if you had no other coverage.

• Secondary plan is a plan that is allowed to reduce its benefits in accordance with COB rules. See COB’s Effect On Benefits later in this section for rules on secondary plan benefits.

• Allowable expense is a health care expense, including deductibles, coinsurance and copayments, 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 isn't covered by any of your plans isn't 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** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

**Primary And Secondary Rules**

Certain governmental plans, such as 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 COB provision that complies with Washington regulations is primary to a complying plan unless the rules of both plans make the complying 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. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

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 but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
  - If a court decree makes both parents responsible for the child’s health care expenses or coverage, the birthday rule determines which plan is primary.
  - If a court decree 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.

**Continuation Coverage** If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that isn't through COBRA or other continuation law.

**Please 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 we do not have your start date under the other plan, we will use the employee's hire date with the other group instead. We will compare that hire date to the date your coverage started under this plan to find out which plan covered you for the longest time.
If none of the rules above apply, the plans must share the allowable expenses equally.

**COB's Effect On Benefits**

The primary plan provides its benefits as if you had no other coverage.

A plan may take into account the benefits of another plan only when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. The secondary plan is never required to pay more than its benefit in the absence of COB plus any savings accrued from prior claims incurred in the same calendar year.

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary. It must also calculate savings for each claim by subtracting its secondary benefits from the amount it would have provided as primary. It must use these savings to pay any allowable expenses incurred during that calendar year, whether or not they are normally covered.

This plan requires you or your provider to ask for prior authorization from Premera Blue Cross before you get certain services or drugs. Your other plan may also require you to get prior authorization for the same service or drug. In that case, when this plan is secondary to your other plan, you will not have to ask Premera for prior authorization of any service or drug for which you asked for prior authorization from your other plan. This does not mean that this plan will cover the service or drug. The service or drug will be reviewed once we receive your claim.

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the consent of anyone to do this. State regulations require each of your other plans and each person claiming benefits under this plan to give us any facts we need for COB. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the primary plan fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim to the secondary plan to make payment as if the secondary plan was primary. In such situations, the secondary plan is required to pay claims within 30 calendar days of receiving your claim and notice that your primary plan has not paid. However, the secondary plan may recover from the primary plan any excess amount paid under the Right of Recovery/Facility Of Payment provision in the plan.

**Right Of Recovery/Facility Of Payment** If your other plan makes payments that this plan should have made, we have the right, at our reasonable discretion, to remit to the other plan the amount we determine is needed to comply with COB. To the extent of such payments, we are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess payment from anyone to whom or for whom the payment was made or from any other issuers or plans. This plan has the right to appoint a third party to act on its behalf in recovery efforts.

Questions about COB? Contact our Customer Service Department or the Washington Insurance Department.

**SUBROGATION AND REIMBURSEMENT**

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we will be subrogated to any rights that you may have to recover compensation or damages from that liable party related to the injury or illness, and we would be entitled to be repaid for payments we made on your behalf out of any recovery that you obtain from that liable party after you have been fully compensated for your loss. The liable party is also known as the “third party” because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor and because we exclude coverage for such benefits.

**Definitions** The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.

- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.

- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan.
Because we have paid for your illness or injuries, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss.

To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of payments we have made on your behalf after you have been fully compensated for your loss. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. In recovering payments made on your behalf, we may at our election hire our own attorney to prosecute a subrogation claim for recovery of payments we have made on your behalf directly from third-parties, or be represented by your attorney prosecuting a claim on your behalf. Our right to prosecute a subrogation claim against third-parties is not contingent upon whether or not you pursue the party at fault for any recovery. If you recover from a third party and we share in the recovery, we will pay our share of the reasonable legal expenses. Our share is that percentage of the legal expenses reasonable and necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. In the event of a trial or arbitration, you must make a claim against, or otherwise pursue recovery from third-parties payments we have made on your behalf, and give us reasonable notice in advance of the trial or arbitration proceeding. (See Notices later in this booklet.) You must also cooperate fully with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of the payments we have paid on your behalf, you are responsible for reimbursing us for payments we have made on your behalf.

You agree, if requested, to hold in trust and execute a trust agreement in the full amount of payments we made on your behalf from any recovery you obtain from any third-party until such time as we have reached a final determination or settlement regarding the amount of your recovery that fully compensates you for your loss.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

We have the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage. We will use our expertise and judgment to reasonably construe the terms of this booklet as they apply to your eligibility for benefits. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal, have independent review or bring a civil challenge to any eligibility determination.

Please note that you do not have to be a citizen of or live in the United States if you are otherwise eligible for coverage.

SUBSCRIBER ELIGIBILITY

To be covered as a subscriber under this plan, an employee must meet all of the following requirements:

- The employee must be a regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group’s payroll system, and reported by the Group for Social Security purposes. The employee must also:
  - Regularly work a minimum of 40 hours per week
  - Complete a 60-day probationary period

Employees Performing Employment Services In Hawaii

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the Group is located) be administered according to Hawaii law. If the Group is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the Group in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the Group there, he or she will no longer be eligible for coverage.
DEPENDENT ELIGIBILITY

To be a dependent under this plan, the family member must be:

- The lawful spouse of the subscriber, unless legally separated. (“Lawful spouse” means a legal union of two persons that was validly formed in any jurisdiction.)
  However, if the spouse is an owner, partner, or corporate officer of the Group who meets the requirements in Subscriber Eligibility earlier in this section, the spouse can only enroll as a subscriber.

- The domestic partner of the subscriber. Domestic partnerships that are not documented in a state domestic partnership registry must meet all requirements as stated in the signed “Affidavit of Domestic Partnership.” All rights, benefits and obligations afforded to a “spouse” under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term “establishment of the domestic partnership” shall be used in place of “marriage”; the term “termination of the domestic partnership” shall be used in place of “legal separation” and “divorce.”

- An eligible dependent child who is under 26 years of age.
  An eligible child is one of the following:
  - A natural offspring of either or both the subscriber or spouse
  - A legally adopted child of either or both the subscriber or spouse
  - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. “Placed” for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
  - A legally placed ward or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrollment is timely when we receive the completed enrollment application and required subscription charges within 60 days of the date the employee becomes an “eligible employee” as defined in the Who Is Eligible For Coverage? section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the latest of the applicable dates below.

The Group may require coverage for some classes of employees to start on the first of the month following the applicable date below, as stated on its Group Master Application. Please contact the Group for information.

- The employee’s date of hire
- The date the employee enters a class of employees to which the Group offers coverage under this plan
- The next day following the date the probationary period ends, if one is required by the Group

If we don’t receive the enrollment application within 60 days of the date you became eligible, none of the dates above apply. Please see Open Enrollment and Special Enrollment later in this section.

Dependents Acquired Through Marriage After The Subscriber’s Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage, coverage will become effective on the date of marriage. If we don’t receive the enrollment application within 60 days of marriage, please see the Open Enrollment provision later in this section.

Natural Newborn Children Born On Or After The Subscriber’s Effective Date

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To extend the child’s coverage beyond the 3-week period, the subscriber should follow the steps below. If the mother isn’t eligible for obstetrical care benefits, but the child qualifies as an eligible dependent, the subscriber should follow the steps below to enroll the child from birth.

- An enrollment application isn’t required for natural newborn children when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for natural newborn children on the
date of birth.

- When subscription charges being paid don’t already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us within 60 days following birth. Coverage becomes effective from the date of birth. If we don’t receive the enrollment application within 60 days of birth, please see the Open Enrollment provision later in this section.

Adoptive Children Acquired On Or After The Subscriber’s Effective Date

- An enrollment application isn’t required for adoptive children placed with the subscriber when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for adoptive children on the date of placement with the subscriber.

- When subscription charges being paid don’t already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us within 60 days following the date of placement with the subscriber. Coverage becomes effective from the date of placement. If we don’t receive the enrollment application within 60 days of the date of placement with the subscriber, please see the Open Enrollment provision later in this section.

Foster Children

To enroll a new foster child, we must get any payment needed, a filled out enrollment form, and a copy of the child’s foster papers. We must get these items no more than 60 days after the date the subscriber became the child’s foster parent. When we get these items on time, the plan will cover the child as of the date the subscriber became the child’s foster parent. If we do not get the items on time, the child must wait for the Group’s next open enrollment period to be enrolled.

Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required subscription charges, and a copy of the guardianship papers within 60 days of the date legal guardianship began with the subscriber, coverage for an otherwise eligible child will begin on the date legal guardianship began. If we don’t receive the enrollment application within 60 days of the date legal guardianship began, please see the Open Enrollment provision later in this section.

Children Covered Under Medical Child Support Orders

When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child’s custodial parent, a state agency administering Medicaid or the state child support enforcement agency. Please contact your Group for detailed procedures.

SPECIAL ENROLLMENT

The plan allows employees and dependents to enroll outside the plan’s annual open enrollment period, if any, only in the cases listed below. In order to be enrolled, the applicant may be required to give us proof of special enrollment rights. If a completed enrollment application is not received within the time limits stated below, further chances to enroll, if any, depend on the normal rules of the plan that govern late enrollment.

Involuntary Loss of Other Coverage

If an employee and/or dependent doesn’t enroll in this plan or another plan sponsored by the Group when first eligible because they aren’t required to do so, that employee and/or dependent may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

- The employee and/or dependent was covered under group health coverage or a health insurance plan at the time coverage under the Group's plan is offered

- The employee and/or dependent's coverage under the other group health coverage or health insurance plan ended as a result of one of the following:
  - Loss of eligibility for coverage for reasons including, but not limited to legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment
  - Termination of employer contributions toward such coverage
The employee and/or dependent was covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted.

An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible employee isn’t enrolled in any of the Group’s plans or is enrolled in a different plan sponsored by the Group, the employee is also allowed to enroll in this plan in order for the dependent to enroll.

We must receive the completed enrollment application and any required subscription charges from the Group within 60 days of the date such other coverage ended. When the 60-day time limit is met, coverage will start on the first of the month that next follows the last day of the other coverage.

**Subscriber And Dependent Special Enrollment**

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer’s group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under Enrollment in the case of marriage, birth or adoption. The eligible employee may also choose to enroll alone, enroll with some or all eligible dependents or change plans, if applicable.

**State Medical Assistance and Children’s Health Insurance Program**

Employees and dependents who are eligible as described in **Who Is Eligible For Coverage?** have special enrollment rights under this plan if one of the statements below is true:

- The person is eligible for state medical assistance, and the Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective to enroll the person in this plan.
- The person qualifies for premium assistance under the state’s medical assistance program or Children's Health Insurance Program (CHIP).
- The person no longer qualifies for health coverage under the state’s medical assistance program or CHIP.

To be covered, the eligible employee or dependent must apply and any required subscription charges must be paid no more than 60 days from the date the applicable statement above is true. An eligible employee who elected not to enroll in this plan when such coverage was previously offered, must enroll in this plan in order for any otherwise eligible dependents to be enrolled in accordance with this provision. Coverage for the employee will start on the date the dependent's coverage starts.

**OPEN ENROLLMENT**

If you’re not enrolled when you first become eligible, or as allowed under Special Enrollment above, you can’t be enrolled until the Group’s next open enrollment period. An open enrollment period occurs once a year unless otherwise agreed upon between the Group and us. During this period, eligible employees and their dependents can enroll for coverage under this plan.

If the Group offers multiple health care plans and you're enrolled under one of the Group’s other health care plans, enrollment for coverage under this plan can only be made during the Group’s open enrollment period.

**CHANGES IN COVERAGE**

No rights are vested under this plan. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

The exception is inpatient confinements described in **Extended Benefits;** please see the How Do I Continue Coverage? section. Changes to this plan won’t apply to inpatient stays that are covered under that provision.

**PLAN TRANSFERS**

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan with us offered by the Group. Transfers also occur if the Group replaces another plan (with us) with this plan. All transfers to this plan must occur during open enrollment or on another date agreed upon by us and the Group.

When we update the contract for this plan, or you transfer from the Group’s other plan with us, and there’s no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied and/or credited under the prior plan:
• Benefit maximums
• Transplant waiting period
• Out-of-pocket maximum
• Calendar year deductible

This provision does not apply to transfers from plans not offered by us.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

Coverage will end without notice, except as specified under Extended Benefits, on the last day of the month in which one of these events occurs:

• For the subscriber and dependents when:
  • The Group contract is terminated
  • The next monthly subscription charge isn’t paid when due or within the grace period
  • The subscriber dies or is otherwise no longer eligible as a subscriber
  • In the case of a collectively bargained plan, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
  • For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
  • For a child when he or she cannot meet the requirements for dependent coverage shown under the Who Is Eligible For Coverage? section.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. The Group must give us written notice of a member’s termination within 30 days of the date the Group is notified of such event.

CONTRACT TERMINATION

No rights are vested under this plan. Termination of the Group Contract for this plan completely ends all members’ coverage and all our obligations, except as provided under Extended Benefits; please see the How Do I Continue Coverage? section below.

This plan is guaranteed renewable. However, this plan will automatically terminate if subscription charges aren’t paid when due; coverage will end on the last day for which payment was made. This plan may also terminate as indicated below.

The Group may terminate the Group Contract:

• Effective on any subscription charge due date, upon 30 days’ advance written notice
• By rejecting in writing the contract changes we make after the initial term. The written rejection must reach us at least 15 days before the changes are to start. The Group Contract will end on the last date for which subscription charges were paid.

We may terminate the Group Contract, upon 30 days advance written notice to the Group if:

• The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage
• The Group fails to meet the minimum participation or contribution requirements stated in its signed application
• The Group no longer has any members who reside or work in Washington
• Published policies, approved by the Office of the Insurance Commissioner, have been violated
• There is a material breach of the Group Contract, other than non-payment
• Changes in or implementation of federal state laws that no longer permit the continued offering of the Group Contract
• We discontinue this Group Contract, as allowed by law.
• We are otherwise permitted to do so by law
HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age (shown under Dependent Eligibility) for a dependent child who can’t support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child’s subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes us with a Request for Certification of Handicapped Dependent form. We must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child’s disability and dependent status when we request it. We won’t ask for proof more often than once a year after the 2-year period following the child’s attainment of the limiting age.

LEAVE OF ABSENCE

Family and Medical Leave Act

This section applies only to groups that must comply with the Federal Family and Medical Leave Act (FMLA). Under FMLA, employers must let an employee and dependents stay on the plan during a leave of absence that meets the requirements of FMLA. Employees have this right if:

- FMLA applies to the employer. In general, employers must comply with FMLA if they have 50 or more employees. FMLA applies to public agencies and private elementary and secondary schools of any size.
- The employee meets FMLA requirements. Employees can keep coverage during an FMLA leave only if they have worked for the employer for 12 months or more and have worked at least 1,250 hours during the last 12 months before the leave is to start.
- The employer approves the leave.
- The leave of absence qualifies under FMLA. These leaves are called “FMLA Leaves” in this booklet. The leave can be unpaid, but the employer must protect the employee’s job during the FMLA leave.
  - FMLA requires covered employers to provide employees up to 12 weeks of leave during a 12-month period for any of the reasons below:
    - For incapacity due to pregnancy, medical care during pregnancy or childbirth.
    - To care for a child after birth or placement for adoption or foster care.
    - To care for a spouse, child or parent who has a serious health condition.
    - For a health condition so serious that the employee cannot do his or her job.
    - In some situations that come up because the employee’s spouse, child or parent is on or is called to active duty in the armed forces overseas.
  - FMLA also lets employees take up to 26 weeks of leave during a 12-month period to care for a spouse, child, parent or next of kin who is a covered member of the armed forces and who has a serious injury or illness. “Covered member of the armed forces” also means a veteran who was discharged from the armed forces (other than a dishonorable discharge) at any time during the 5 years before the FMLA leave starts.

Note: The law does not consider a domestic partner to be a spouse.

The subscriber must pay his or her normal share of the subscription charges during the leave.

The subscriber and some or all covered family members can choose not to stay on the plan during the FMLA leave. In that case, they can be enrolled again when the subscriber returns to work at the end of the FMLA leave. Coverage will start on the date the subscriber returns to work.

If the subscriber does not return to work at the end of the FMLA leave, the subscriber and covered family members must pay their normal share of the subscription charges during the FMLA leave.
members will have a right to elect COBRA coverage. The FMLA leave period does not count as part of the COBRA period.

Eligible subscribers must give the Group 30 days advance notice when they know ahead of time that they need to take a leave of absence.

This is only a summary of what FMLA requires. Please contact the Group to learn more about FMLA leaves. If the FMLA requirements change, this plan will comply with the changes.

The Group must keep Premera Blue Cross advised about the eligibility for coverage of any employee who may have a right to benefits under FMLA.

**Other Leaves of Absence**

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by state or other federal laws, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid. The requirements and the length of leave may vary. Please contact the Group for details.

The leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

**LABOR DISPUTE**

A subscriber may pay subscription charges through the Group to keep coverage in effect for up to 6 months in the event of suspension of compensation due to a lockout, strike, or other labor dispute.

The 6-month labor dispute period counts toward the maximum COBRA continuation period.

**COBRA**

When group coverage is lost because of a “qualifying event” shown below, federal laws and regulations known as “COBRA” require the Group to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay the subscription charges for it.

At the Group's request, we'll provide qualified members with COBRA coverage under this plan when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us. The Group, not us, is responsible for all notifications and other duties assigned by COBRA to the “plan administrator” within COBRA's time limits.

The following summary of COBRA coverage is taken from COBRA. Members' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

**Qualifying Events And Length Of Coverage**

Please contact the Group immediately when one of the qualifying events highlighted below occurs. The continuation periods listed extend from the date of the qualifying event.

Covered domestic partners and their children have the same rights to COBRA coverage as covered spouses and their children.

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
  - The subscriber's work hours are reduced.
  - The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.

- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA
may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.

- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
  - The subscriber dies.
  - The subscriber and spouse legally separate or divorce.
  - The subscriber becomes entitled to Medicare.
  - A child loses eligibility for dependent coverage.

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

**Conditions Of COBRA Coverage**

For COBRA coverage to become effective, all of the requirements below must be met:

**You Must Give Notice Of Some Qualifying Events**

The plan will offer COBRA coverage only after the Group receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in *Qualifying Events and Length Of Coverage*. The subscriber or affected dependent must also notify the Group if the Social Security Administration determines that the subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Group this notice for you.

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage. Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the later of: 1) the date the subscriber's termination or reduction in hours; 2) the date the qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. *Please note: Determinations that a qualified member is disabled must be given to the Group before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice.* Please include a copy of the determination with your notice to the Group.

  - Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See *When COBRA Coverage Ends*.

- For the other events above, the 60-day notice period starts on the later of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

**Important Note: The Group must tell you where to direct your notice and any other procedures that you must follow. If the Group informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you’re informed by the Group.**

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the group. In such cases, the Group has 30 days in which to notify its plan administrator of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement. The plan administrator then has 14 days after it receives notice of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Group itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Group must furnish the notice required because of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement no later than 44 days after the later of 1) the date of the qualifying event, or 2) the date coverage would end in the absence of COBRA. For all other qualifying events, the 14-day notice time limit applies.
You Must Enroll And Pay On Time

- You must elect COBRA coverage no more than 60 days after the later of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Please contact the Group or your bargaining representative for more information if you believe this may apply to you.

Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

If you’re not notified of your right to elect COBRA coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you’re not notified of your right to elect COBRA coverage within the time limit, and you don’t elect COBRA coverage within 60 days after the date coverage ends, we won’t be obligated to provide COBRA benefits under this plan. The Group will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.

- You must send your first subscription charge payment to the Group no more than 45 days after the date you elected COBRA coverage.

- Subsequent subscription charges must be paid to the Group and submitted to us with the Group’s regular monthly billings.

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under Special Enrollment or Open Enrollment in the When Does Coverage Begin? section. With one exception, family members added after COBRA begins aren’t eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under Qualifying Events And Length Of Coverage earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep The Group Informed Of Address Changes

In order to protect your rights under COBRA, you should keep the Group informed of any address changes. It is a good idea to keep a copy, for your records, of any notices you send to the Group.

When COBRA Coverage Ends

COBRA coverage will end on the last day for which subscription charges have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly subscription charge isn’t paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see Qualifying Events And Length Of Coverage in this section), COBRA coverage beyond 18 months ends if there’s a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won’t end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the later of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.
- You become covered under another group health care plan after the date you elect COBRA coverage.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group health care coverage to any employee.

However, even if one of the events above hasn't occurred, COBRA coverage under this plan will end on the date that the contract between the Group and us is terminated.
When COBRA coverage under this plan ends, you may be eligible for benefits as described in **Extended Benefits** later in this section. You may also be eligible to apply for one of our individual plans as explained in **Converting To A Non-Group Plan** later in this section.

**If You Have Questions**

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Group. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

### 3-MONTH CONTINUATION OF GROUP COVERAGE

You may choose to extend your coverage under this plan for up to 3 months past the date your coverage ended if:

- Your Group isn’t subject to COBRA.
- You’re not eligible for COBRA coverage.
- Your Group coverage ends for reasons other than as described under **Intentionally False Or Misleading Statements**.

You must send your first subscription charge payment and completed application to the Group by the due date determined by the Group. The Group will in turn send us your subscription charge payment and completed application form with the first payment it makes on or after the date your coverage ended. Subsequent subscription charge payments must be paid to the Group, by the date determined by the Group, and forwarded to us by the Group with their regular monthly billings.

Continued coverage under this plan may end before the 3-month period expires. It will end on the last day of the monthly period for which subscription charges have been paid in which the first of the following occurs:

- The next monthly subscription charge isn’t paid when due or within the grace period
- The contract between the Group and us is terminated

The 3-month continuation period isn't available once COBRA coverage is exhausted.

### EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than as described under **Intentionally False Or Misleading Statements**. If the contract between the Group and us is terminated while you’re receiving the extended benefits below, your right to those benefits won’t be affected.

The inpatient benefits of this plan will continue to be available after coverage ends if:

- Your coverage didn’t end because of fraud or an intentional misrepresentation of material fact under the terms of the coverage by you or the Group
- You were admitted to a medical facility prior to the date coverage ended
- You remained continuously confined in a medical facility because of the same medical condition for which you were admitted

**Please Note:** Newborns are eligible for Extended Inpatient benefits only if they are enrolled beyond the 3-week period specified in the **Newborn Care** benefit.

Such continued inpatient coverage will end when the first of the following occurs:

- You’re covered under a health plan or contract that provides benefits for your confinement or would provide benefits for your confinement if coverage under this plan did not exist
- You’re discharged from that facility or from any other facility to which you were transferred
- Inpatient care is no longer medically necessary
- The maximum benefit for inpatient care in the medical facility has been provided. If the calendar year ends before a calendar year maximum has been reached, the balance is still available for covered inpatient care you receive in the next year. Once it's used up, however, a calendar year maximum benefit will not be renewed.
CONTINUATION UNDER USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are re-employed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

CONVERTING TO A NON-GROUP PLAN

You may be entitled to coverage under an Individual plan when your coverage under this plan ends. Individual plans differ from this plan. You pay the monthly payment. You must apply and send the first subscription charge payment within 60 days of the date your coverage ends or you were first notified that your coverage had ended under this plan, whichever is later.

You can apply for an Individual plan if you live in Washington State and you’re not eligible for Medicare coverage, and you’re not entitled to services or benefits for medical and hospital care under another group plan.

For more information about Individual plans, contact your employer or our Customer Service department.

Please Note: The rates, coverage and eligibility requirements of Individual plans differ from those of your current group plan.

MEDICARE SUPPLEMENT COVERAGE

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you may be eligible for guarantee-issued coverage under certain Medicare supplement plans if you apply within 63 days of losing coverage under this plan. For more information, contact your producer or our Customer Service department.

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

Many providers will submit their bills to us directly. However, if you need to submit a claim for medical benefits to us, follow the simple steps below.

Step 1

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service.

Step 2

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber’s identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or diagnosis code from the most current edition of the International Classification of Diseases manual.
- Procedure codes from the most current edition of the Current Procedural Terminology manual, the Healthcare Common Procedure Coding manual, or the American Dental Association Current Dental Terminology manual for each service
- Dates of service and itemized charges for each service rendered
• If the services rendered are for treatment of an injury, the date, time, location and a brief description of the event

**Step 3**

If you’re also covered by Medicare, and Medicare is primary, you must attach a copy of the “Explanation of Medicare Benefits.”

**Step 4**

Check that all required information is complete. Bills received won’t be considered to be claims until all necessary information is included.

**Step 5**

Sign the Subscriber Claim Form in the space provided.

**Step 6**

Mail your claims to us at the mailing address shown on the back cover of this booklet.

**Prescription Drug Claims**

To make a claim for covered prescription drugs, please follow these steps:

**Participating Pharmacies**

For retail pharmacy purchases, you don’t have to send us a claim. Just show your Premera Blue Cross ID card to the pharmacist, who will bill us directly. If you don’t show your ID card, you’ll have to pay the full cost of the prescription and submit the claim yourself.

For mail-order pharmacy purchases, you don’t have to send us a claim, but you’ll need to follow the instructions on the order form and submit it to the address printed on the form. Please allow up to 14 days for delivery.

**Non-Participating Pharmacies**

You’ll have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You’ll need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

If you need a supply of participating mail-order pharmacy order forms or prescription drug claim forms, contact our Customer Service department at the numbers shown on the back cover of this booklet.

**Timely Filing**

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. 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 or supplies

• 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’ll make every effort to process your claims as quickly as possible. We process claims in the order in which we receive them. We’ll tell you if this plan won’t cover all or part of the claim no later than 30 days after we first receive it. This notice will be in writing. We can extend the time limit by up to 15 days if it’s decided that more time is needed due to matters beyond our control. We’ll let you know before the 30-day time limit ends if we need more time. If we need more information from you or your provider in order to decide your claim, we’ll ask for that information in our notice and allow you or your provider at least 45 days to send us the information. In such cases, the time it takes to get the information to us doesn’t count toward the decision deadline. Once we receive the information we need, we have 15 days to give you our decision.

If your claim was denied, in whole or in part, our written notice (see Notices) will include:

• The reasons for the denial and a reference to the provisions of this plan on which it’s based
A description of any additional information we may need to reconsider the claim and why that information is needed

A statement that you have the right to appeal our decision

A description of our complaint and appeal processes

If there were clinical reasons for the denial, you’ll receive a letter from our medical department stating these reasons. The letter will also include how ongoing care may be covered during the appeal process, as described in When You Have An Appeal below.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer or a friend or relative. You must notify us in writing and give us the name, address and telephone number where your appointee can be reached.

If all you have to pay is a copay for a covered service or supply, it is not considered a claim for benefits. However, you always have the right to get a paper copy of your explanation of benefits for the service or supply. You can call Customer Service. The phone number is on the back cover of your booklet and on your Premera ID card. Or, you can visit our website for secure online access to your claims. If your claim is denied in whole or in part, you may send us a complaint or appeal as outlined under Complaints And Appeals.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in this plan, you may file suit in a state or federal court.

COMPLAINTS AND APPEALS

As a Premera Blue Cross member you have the right to offer your ideas, ask questions, voice complaints and submit appeals. Our goal is to listen, resolve your problems, and improve our service to you.

When You Have Ideas

We want to hear from you on ways we can continue to improve our service. If you have an idea, suggestion or opinion, please let us know. You can call our Customer Service department at the numbers listed on the back cover of this booklet, or send your ideas and comments to our Customer Assessment Manager at the Customer Service address on the back cover of this booklet.

When You Have Questions

Call your provider of care when you have questions about the health care services you receive. Please call our Customer Service department with any other questions regarding your Premera Blue Cross plan.

When You Have A Complaint

A complaint is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but don’t require, that you take advantage of this process when you’re not content with a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, a representative will tell you.

When you have a complaint, call or write our Customer Service department. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We’ll let you know when we’ve received your complaint. We also may request more information when needed. When we receive all needed information, we’ll review your complaint and respond as soon as possible, but never more than 30 calendar days.

When You Have An Appeal

An appeal is an oral or written request that we reconsider 1) our decision on a complaint, or 2) our decision to deny, modify, reduce, or end payment, coverage or authorization of coverage. This includes admissions to and continued stays in a facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you’re appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

Although we’ll accept an appeal made by phone to our Customer Service department, it’s a better idea to put appeals in writing so you can keep copies for your records. Please send all written appeals to the address shown
on the back cover of this booklet. We’ll let you know when we receive your appeal.

You have the right to give us comments, documents or other information to support your appeal. You can also request to review documents relevant to your claim.

**Appeals Process**

Our standard appeals process has 2 levels of review. We’ll give you our appeal decisions in writing.

**Level I** The Level I Appeal panel will give you its decision within 30 calendar days. This panel will include health care providers who weren’t involved in the initial decision.

There are 4 exceptions to the 30-day time limit:

- **A decision to change, reduce or end an ongoing service**
  
  We’ll mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than an additional 15 calendar days.

- **Denial of an experimental or investigational service**
  
  We’ll mail you a response within 20 calendar days from the date we receive your appeal. The 20-day period may be extended for up to 10 more calendar days with your informed written consent.

- **Denials made before you receive the service**
  
  We’ll decide these appeals no more than 14 calendar days after we receive them.

- **Urgent Appeals** (please see the Urgent Appeals provision below)

If you don’t agree with the decision reached in our Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. **You must make your request for a Level II review no more than 60 calendar days after the date you receive our Level I decision.** This time limit may be extended in the event the member needs to obtain additional medical documentation, physician consultations or opinions, if the member is hospitalized or traveling, or for other reasonable cause beyond the member’s control. In no case shall the extension exceed 180 days.

**Level II** Your appeal will be reviewed by a Premera Blue Cross panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel.

Level II appeal decisions will be given to you within 30 calendar days after we receive your level II request, with 2 exceptions noted below:

- **Urgent appeals (see Urgent Appeals below)**

- **You’re appealing a benefit determination that was made before you received the services.** We’ll decide these appeals no more than 14 calendar days after we receive them.

If you’re appealing a decision to deny, change, reduce or end payment, coverage or authorization of coverage, and you’re not satisfied with the outcome of the Level II appeal, you may ask for an independent review (please see the Independent Review provision below). You may also ask for an independent review if we don’t give you our Level I or Level II decision within the time limits stated. We must receive your request for independent review within 60 calendar days of the date that the appeal decision was due.

You also have the right to file suit in state or federal court if you’re not satisfied with the outcome of the Level II appeal.

**Independent Review** Independent reviews are conducted by an independent review organization (IRO), which is an organization of medical experts qualified to review your appeal. We’ll useIROs that have been certified by the state Department of Health. We’ll submit your file to the IRO on your behalf and will pay the charges of the IRO. The IRO will give you its decision in writing. We’ll implement the IRO’s determination promptly.

**Urgent Appeals** We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and II responses on urgent appeals will be given within 72 hours after the appeal is received.

**Appeals Of Ongoing Care** While you’re appealing a decision to change, reduce or end coverage because the service or level of service is no longer medically necessary or appropriate, we’ll suspend our denial. Our coverage for services received during the appeal period doesn’t and shouldn’t be construed to reverse our denial. **If our initial decision is upheld, you must repay us all amounts that we’ve paid for such services. You’ll also have to pay providers any difference between our allowable charge and the provider’s billed charge.**
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:

- How to access care under this plan, including from providers who do not contract with us. See How Does Selecting A Provider Affect My Benefits? earlier in this booklet.
- Our confidentiality policies
- Your right to seek and pay for care outside of this plan
- The plan’s drug list, also called a “formulary”
- 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 appeal decisions you don't agree with.
- How to access specialists
- How to get prior authorization when needed
- How we monitor quality and performance, including accreditation status of our plans with 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 Web site. If you don’t have access to the Web, please call Customer Service. Our Web address and phone numbers are shown on the back cover of this booklet.

Also, when you enrolled in this plan, you got information such as how to access our provider directory and preferred drug lists. If you need this information again, please call Customer Service.

You may also ask Customer Service for more information about:

- Other healthcare plans we offer
- A descriptions of the payment arrangements we use to pay providers

OTHER INFORMATION ABOUT THIS PLAN

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.

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
- The benefit booklet(s)
- The Group’s signed application
- The Funding Arrangement Agreement between the Group and us
- All attachments, endorsements and riders included or issued hereafter
No agent or representative of Premera Blue Cross 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 over the signature of an officer of Premera Blue Cross.

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 health care providers. No benefits will be available if the proof isn't provided or acceptable to us.

The Group And You

Your Group is your representative for all purposes under this plan and not the representative of Premera Blue Cross. Any action taken by the Group will be binding on you.

Healthcare Providers — Independent Contractors

All healthcare providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this plan or the contract between Premera Blue Cross and the Group 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.

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. Please see the Right Of Recovery provision 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.

Please 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.

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.

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, health care providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.)
- Coordinating benefits with other health care plans
- Conducting care 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

**Notices**

Any notice we’re required to submit to the Group or subscriber will be considered to be delivered if it’s mailed to the Group or subscriber at the most recent address appearing on our records. We’ll use the date of postmark in determining the date of our notification. If you or your Group is required to submit notice to us, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

**Right Of Recovery**

We have the right to recover amounts we paid that exceed the amount for which we’re 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 his or her dependents (even if the original payment wasn’t 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 the contract for this plan is rescinded 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; and
- 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.

**Workers’ Compensation Insurance**

This contract doesn’t replace, affect or supplement any state or federal requirement for the Group to provide workers’ compensation insurance, employer’s liability insurance or other similar insurance. When an employer is required by law to provide or has the option to provide workers’ compensation insurance, employer’s liability insurance or other similar insurance and doesn’t provide such coverage for its employees, the benefits available under this plan won’t be provided for illnesses and/or injuries arising out of the course of employment that are or would be covered by such insurance, unless otherwise excepted under the *What’s Not Covered?* section in this booklet.

**WHAT ARE MY RIGHTS UNDER ERISA?**

The Group has an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the “ERISA Plan” in this section. The insured Premera Blue Cross plan described in this booklet is part of the ERISA Plan.

When used in this section, the term “ERISA Plan” refers to the Group’s employee welfare benefit plan. The “ERISA Plan administrator” is the Group or an administrator named by the Group. Premera Blue Cross is **not** the ERISA plan administrator.

As participants in an employee welfare benefit plan, subscribers have certain rights and protections. This section of this plan explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator’s office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. (Please note that our contract with the Group by itself does not meet all the requirements for an ERISA plan document.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.

- Receive a summary of the ERISA Plan’s annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there’s a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. (Premera Blue Cross is a fiduciary only with respect to claims processing and payment.) No one, including your employer, the Group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the...
materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan’s money, or if you’re discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you’re successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either the:

- Office of the Employee Benefits Security Administration, U.S. Department of Labor, 300 Fifth Ave., Suite 1110, Seattle, WA 98104; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan. As part of the routine operation of this plan, we use our expertise and judgment to apply the terms of the contracts for making decisions in specific benefits, eligibility and claims situations. For example, we use the medical judgment and expertise of Medical Directors to determine whether claims for benefits meet the definitions below of “Medically Necessary” or “Experimental/Investigational 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 rights you may have under applicable state or federal law to appeal, have independent review or bring a civil challenge to any eligibility or claims determinations.

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).

Allowable Charge

This plan provides benefits based on the allowable charge for covered services. We reserve the right to determine the amount allowed for any given service or supply. The allowable charge is described below. There are different rules for emergency services. These rules are shown below the general rules.

General Rules

- **Providers In Washington and Alaska Who Have Agreements With Us**
  For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You’ll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.
  Your liability for any applicable calendar year deductibles, coinsurance, copays and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

- **Providers Outside The Service Area Who Have Agreements With Other Blue Cross Blue Shield Licensees**
  For covered services and supplies received outside the service area, allowable charges are determined as stated in the “What Do I Do If I’m Outside Washington And Alaska?” section (**Out-Of-Area Care**) in this booklet.
• **Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee**
  The allowable charge for providers in the service area that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside the service area that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.
  - An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us
  - 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
  - The provider’s billed charges. Note: Ambulances are always paid based on billed charges.
  If applicable law requires a different allowable charge than the least of the three amounts above, this plan will comply with that law.

**Emergency Care**
Consistent with the requirements of the Affordable Care Act, the allowable charge will be the greatest of the following amounts:
- The median amount that Heritage Prime network providers have agreed to accept for the same services
- The amount Medicare would allow for the same services
- The amount calculated by the same method the plan uses to determine payment to non-network providers above the allowable charge.

In addition to your deductible, copays and coinsurance, you will be responsible for charges received from non-network providers above the allowable charge.

When you receive services from providers that **don’t** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowable charge, and for your normal share of the allowable charge (see the **What Are My Benefits?** section for further detail).

Note: Non-contracted ambulances are always paid based on billed charges.

The allowed amount will be the amount allowed for out-of-network providers even when the provider’s services are covered at the in-network benefit level.

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

**Ambulatory 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

**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.

**Chemical Dependency**
An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It’s further characterized by a frequent or intense pattern of pathological use to the extent:
- The user exhibits a loss of self-control over the amount and circumstances of use
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued
- The user’s health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

**Community Mental Health Agency**
An agency that’s licensed as such by the state of Washington to provide mental health treatment under the
supervision of a physician or psychologist.

**Congenital Anomaly Of A Dependent Child**

A marked difference from the normal structure of an infant's body part, that's present from birth and manifests during infancy.

**Cost-Share**

The member’s share of the allowable charge for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See *What Are My Benefits?* to find out what your cost-share is.

**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 supervision over self-administration of medication not requiring constant attention of trained medical personnel

**Detoxification**

Detoxification is active medical management of medical conditions due to substance intoxication or substance withdrawal, which requires repeated physical examination appropriate to the substance, and use of medication. Observation alone is not active medical management.

**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 an employee or dependent is eligible to be covered under the Group’s health care plan. If an employee 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 Care**

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. “Stabilize” means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
- Ambulance transport as needed in support of the services above.

**Enrollment Date**

For a subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber’s date of hire. There is one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn’t provide coverage under this plan, but was later transferred to a class of employees to which the Group does provide coverage under this plan, the enrollment date is the date the subscriber entered the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.) For subscribers who don’t enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.

**Essential Health Benefits**

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general
categories: ambulatory patient services, emergency care, hospitalization, maternity and newborn care, mental health and chemical dependency services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device that can’t be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn’t been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Group

The large employer that is a party to the Group Contract. A large employer is one that had an average of at least 51 common law employees on its normal work days in the preceding calendar year. It must also have at least 51 common law employees on the first day of the current contract term.

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A “hospital” will never be an institution that’s run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition or pregnancy.

Injury

Physical harm caused by a sudden event at a specific time and place. It’s independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical Emergency

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) 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
woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

**Medical Equipment**

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It's of no use in the absence of illness or injury.

**Medical Facility (also called “Facility”)**

A hospital, skilled nursing facility, state-approved chemical dependency treatment program or hospice.

**Medically Necessary**

Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to 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 generally 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.

**Member (also called “You” and “Your”)**

A person covered under this plan as a subscriber or dependent.

**Network Provider**

A provider that is in one of the networks stated in the *How Does Selecting A Provider Affect My Benefits?* section.

**Non-Contracted Provider**

A provider is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

**Non-Network Provider**

A provider that is not in one of the provider networks stated in the *How Does Selecting A Provider Affect My Benefits?* section.

**Obstetrical Care**

Care furnished during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Abortion is included as part of obstetrical care.

**Orthodontia**

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

**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 an inpatient in a medical facility.

Participating Pharmacy (Participating Retail/Participating Mail-Order Pharmacy)
A licensed pharmacy which contracts with us or our Drug Benefit Manager to provide prescription drug benefits.

Pharmacy Benefit Manager
An entity that contracts with us to administer the Prescription Drugs benefit under this plan.

Physician
A state-licensed:
- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:
- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.) licensed in Washington state

Plan (also called “This Plan”)
The benefits, terms and limitations set forth in the contract between us and the Group, of which this booklet is a part.

Prescription Drug
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)
- The Federal Secretary of Health and Human Services

“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.
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 his or her 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.

In states other than Washington, “provider” means health care practitioners and facilities licensed or certified consistent with the laws and regulations of the state in which they operate, and provide health care services consistent with applicable state requirements.

In Washington State, covered licensed or certified 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:

- Acupuncturists (L.Ac.) (in Washington, also called East Asian Medicine Practitioners (E.A.M.P.))
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists
The following health care facilities and other providers of health care services and supplies will be considered health care providers for the purposes of this plan, as long as they’re licensed or certified by the State (unless otherwise stated) and the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- 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)

Board Certified Behavior Analysts (BCBAs) will be considered health care providers for the purposes of providing applied behavior analysis (ABA) therapy, as long as both of the following are true: 1) They’re licensed when required by the State in which they practice, or, if the State does not license behavior analysts, are certified as such by the Behavior Analyst Certification Board, and 2) The services they furnish are consistent with state law and the scope of their license or board certification. Therapy assistants/behavioral technicians/paraprofessionals that do not meet the requirements above will also be covered providers under this plan when they provide ABA therapy and their services are supervised and billed by a BCBA or one of the following state-licensed provider types: psychiatrist, developmental pediatrician, pediatric neurologist, psychiatric nurse practitioner, advanced nurse practitioner, occupational or speech therapist, psychologist, community mental health agency that is also state-certified to provide ABA therapy.

**Psychiatric Condition**

A condition listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse.

**Service Area**

The area in which we directly operate provider networks. This area is made up of the states of Washington (except Clark County) and Alaska.

**Skilled Care**

Care that’s ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

**Skilled Nursing Facility**

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that’s approved by Medicare or would qualify for Medicare approval if so requested.

**Subscriber**

An enrolled employee of the Group. Coverage under this plan is established in the subscriber’s name.

**Subscription Charges**

The monthly rates set by us as consideration for the benefits offered in this plan.

**Temporomandibular Joint (TMJ) Disorders**

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the
temporomandibular joint.

**We, Us and Our**

Means Premera Blue Cross in the state of Washington, and Premera Blue Cross Blue Shield of Alaska in the state of Alaska.
Where To Send Claims

MAIL YOUR CLAIMS TO
Premera Blue Cross
P.O. Box 91059
Seattle, WA  98111-9159

PRESCRIPTION DRUG CLAIMS
Mail Your Prescription Drug Claims To:
Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000
Contact the Pharmacy Benefit Manager At:
1-800-391-9701
www.express-scripts.com

Customer Service
Mailing Address
P.O. 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:
1-800-722-1471
Local and toll-free TTY number:
1-800-842-5357

Care Management
Prior Authorization And Emergency Notification
Premera Blue Cross
P.O. Box 91059
Seattle, WA  98111-9159
Local and toll-free number:
1-800-722-1471
Fax: 1-800-843-1114

Telehealth
You can get telehealth care from Teladoc. Log onto your account at member.teladoc.com/premera or call 1-855-332-4059.

Complaints And Appeals
Premera Blue Cross
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA  98111-9202
Fax: (425) 918-5592

BlueCard
1-800-810-BLUE(2583)
Website
Visit our website www.premera.com for information and secure online access to claims information

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association