Balance Gold 1000 Basic

Balance Gold 1000 Basic

49831WA1820001

PREMERA | BLUE CROSS

INTRODUCTION

Welcome

Thank you for choosing Premera Blue Cross (Premera) for your healthcare coverage.

This benefit booklet tells you about your plan benefits and how to make the most of them. Please read this benefit booklet to find out how your healthcare plan works.

Some words have special meanings under this plan. Please see ***Definitions*** at the end of this booklet.

In this booklet, the words "we," "us," and "our" mean Premera. The words "you" and "your" mean any member enrolled in the plan. The word "plan" means your healthcare plan with us.

Please contact Customer Service if you have any questions about this plan. We are happy to answer your questions and hear any of your comments.

On our website at premera.com you can also:

- Learn more about your plan
- Find a healthcare provider near you
- Look for information about many health topics

We look forward to serving you and your family. Thank you again for choosing Premera.

This benefit booklet is for members enrolled in this plan. This benefit booklet describes the benefits and other terms of this plan. It replaces any other benefit booklet you may have received.

We know that healthcare plans can be hard to understand and use. We hope this benefit booklet helps you understand how to get the most from your benefits.

The benefits and provisions described in this plan are subject to the terms of the master group contract (contract) issued to the employer. The employer is the firm, corporation or partnership that contracts with us. This benefit booklet is a part of the contract on file at the employer's office.

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

This plan will comply with the federal health care reform law, called the Affordable Care Act (see ***Definitions***), including any applicable requirements for distribution of any medical loss ratio rebates and actuarial value requirements. If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including changes which become effective on the beginning of the calendar year, 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.

Translation Services

If you need an interpreter to help with verbal translation services, please call us. Customer Service will be able to guide you through the service. The phone number is shown on the back cover of your booklet.

Group Name:	Balance Gold 1000 Basic
Effective Date:	January 1, 2017
Group Number:	49831WA1820001
Plan:	Premera Blue Cross Balance Gold 1000 Basic
Certificate Form Number:	49831WA182 (01-2017)

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,
800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة.
اتصل بـ(TTY: 800-842-5357) 800-722-1471

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)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian): Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese): この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 **(Korean):**
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ **(Lao):**
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់ៗ
សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការវាំប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមានកាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریقPremera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

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 zwrócic 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. Zadzwońcie 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 datas 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).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 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 страхового 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).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 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).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).

HOW TO USE THIS BENEFIT BOOKLET

Every section in this benefit booklet has important information. You may find that the sections below are especially useful.

- **How to Contact Us** – Our website, phone numbers, mailing addresses and other contact information are on the back cover.
- **Summary of Your Costs** – Lists your costs for covered services.
- **Important Plan Information** – Describes deductibles, copays, coinsurance, out-of-pocket maximums and allowed amounts
- **How Providers Affect Your Costs** – How using an in-network provider affects your benefits and lowers your out-of-pocket costs
- **Prior Authorization**– Describes our prior authorization and emergency admission notifications provision
- **Clinical Review** – Describes our clinical review provision
- **Personal Health Support Programs** – Describes our health support programs
- **Continuity of Care** – Describes how to continue care at the in-network level of benefits when a provider is no longer in the network
- **Covered Services** –A detailed description of what is covered
- **Exclusions** – Describes services that are not covered
- **Other Coverage** – Describes how benefits are paid when you have other coverage and what you must do when a third party is responsible for an injury or illness
- **Sending us a Claim** –Instructions on how to send in a claim
- **Complaints and Appeals** – What to do if you want to file a complaint, or an appeal
- **Eligibility and Enrollment** – Describes who can be covered.
- **Termination of Coverage** – Describes when coverage ends
- **Continuation of Coverage** – Describes how you can continue coverage after your group plan ends
- **Other Plan Information** – Lists general information about how this plan is administered and required state and federal notices
- **Definitions** – Meanings of words and terms used

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PREMERA BLUE CROSS BALANCE GOLD 1000 BASIC

This plan uses the following networks:

- **Heritage Signature** medical network
- **Dental Choice** dental network

SUMMARY OF YOUR COSTS

This is a summary of your costs for covered services. Your costs are subject to the all of the following.

- The allowed amount. This is the most this plan allows for a covered service. See ***Important Plan Information*** for details. Non-contracted providers may bill you for amounts over the allowed amount, even when the cost share says *No charge*.
- The **copays**. These are set dollar amounts you pay at the time you get services. Only one office visit copay per provider per day will apply. If the copay amounts are different, the highest will apply. If the amount billed is less than the copay, you only pay the amount billed. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary.
- The **deductible**. The below amount you pay before this plan covers healthcare costs.

	In-Network Providers	**Out-of-Network Providers**
Individual deductible	$1,000	$2,000
Family deductible (embedded)	$2,000	Not applicable

- The out-of-pocket maximum. This is the most you pay each calendar year for services from in-network providers.

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$5,000	Not applicable
Family out-of-pocket maximum	$10,000	Not applicable

- Prior authorization. Some services must be authorized in writing before you get them, in order to be eligible for benefits. See ***Prior Authorization*** for details. The conditions, time limits and maximum limits are described in this booklet. Some services have special rules. See ***Covered Services*** for these details.

  This plan complies with state and federal regulations about diabetes medical treatment coverage. Please see the ***Preventive Care***, ***Prescription Drugs***, ***Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics***, and the ***Foot Care*** benefits.

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
COMMON MEDICAL SERVICES		
Office and Clinic Visits You may have additional costs for other services such as x-rays, lab, therapeutic injections and hospital facility charges. See those covered services for details. Add on facility charges may apply.		
• Office visits with your PCP. See ***How Providers Affect Your Costs***.	No charge first 2 visits per calendar year, then $10 copay, deductible waived	Deductible, then 50% coinsurance
• Telehealth services. See ***Telehealth Virtual Care Services***.	$10 copay, deductible waived	Deductible, then 50% coinsurance
• Office visits for women's health. For example, gynecologist.	$10 copay, deductible waived	Deductible, then 50% coinsurance
• All other office and clinic visits (including consultations with a pharmacist)	$40 copay, deductible waived	Deductible, then 50% coinsurance
Home Based Chronic Care Evaluation and management services of multiple chronic conditions provided by a doctor or nurse practitioner in your place of residence. Some services, such as x-rays, lab, and durable medical supplies charges may have additional cost to you. See those covered services for details.	No charge	Not covered
Preventive Care		
• Exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender	No charge	Not covered
• Seasonal and travel immunizations (pharmacy mass immunizer, travel clinic and county health department)	No charge	No charge
• Health education, preventive nutritional therapy for diseases such as diabetes, and tobacco use cessation programs		
Diagnostic Lab, X-ray and Imaging		
• Preventive care screening and tests	No charge	Deductible, then 50% coinsurance
• Basic diagnostic lab, x-ray and imaging	20% coinsurance, deductible waived	Deductible, then 50% coinsurance
• Major diagnostic x-ray and imaging	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Pediatric Care Limited to members under age 19		
Pediatric Vision Services		

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
• Vision screening (see ***Preventive Care***)	No charge	Not covered
• Comprehensive vision exams limited to one per calendar year	$40 copay, deductible waived	$40 copay, deductible waived
• One pair glasses per calendar year, frames and lenses. Lens features limited to polycarbonate lenses and scratch resistant coating.	No charge	No charge
• One pair of contacts or a 12-month supply of contacts per calendar year, instead of glasses (lenses and frames)	No charge	No charge
• Contact lenses and glasses required for medical reasons	No charge	No charge
• One comprehensive low vision evaluation and four follow up visits in a five calendar year period	No charge	No charge
• Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary	No charge	No charge
Pediatric Dental Services See the ***Pediatric Dental Services*** benefit for details.		
• Class I Services	No charge	Deductible, then 30% coinsurance
• Class II Services	20% coinsurance, deductible waived	Deductible, then 40% coinsurance
• Class III Services (including medically necessary orthodontia for cleft lip and palate, cleft palate, cleft lip with alveolar process involvement or other craniofacial anomalies)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
Prescription Drugs– Retail Pharmacy Up to a 30-day supply. *Must use contracted pharmacy.*		
• Preventive drugs required by federal healthcare reform. See ***Covered Services*** for details.	No charge	Not covered
• Formulary preferred generic drugs	$10 copay, deductible waived	Not covered
• Formulary preferred brand drugs	$40 copay, deductible waived	Not covered
• Formulary non-preferred drugs	$80 copay, deductible waived	Not covered
• Oral chemotherapy drugs	20% coinsurance, deductible waived	Deductible, then 50% coinsurance
Prescription Drugs – Mail-Order Pharmacy Up to a 90-day supply. *Must use contracted pharmacy.*		
• Preventive drugs required by federal healthcare reform. See ***Covered Services*** for details.	No charge	Not covered
• Formulary preferred generic drugs	$30 copay, deductible waived	Not covered
• Formulary preferred brand drugs	$120 copay, deductible waived	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
• Formulary non-preferred drugs	$240 copay, deductible waived	Not covered
Prescription Drugs– Specialty Pharmacy Up to a 30-day supply. *Must use contracted pharmacy.*	20% coinsurance, deductible waived	Not covered
Hospital and Surgery Services		
• Inpatient hospital	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
• Outpatient hospital, ambulatory surgical center (including surgery to implant cochlear implants)	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
• Professional services	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Emergency Room In- and out-of-network emergency room services covered at the same cost shares		
You may have additional costs for other services such as x-rays, lab, and professional services. See those covered services for details.	$200 copay, then in-network deductible, 20% coinsurance	$200 copay, then in-network deductible, 20% coinsurance
(The copay is waived if you are admitted as an inpatient through the emergency room.)		
• Other professional and facility services	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance
Emergency Ambulance Services	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance
Urgent Care Centers		
• Non-hospital urgent care centers. You may have additional costs for other services such as x-rays, lab, therapeutic injections and hospital facility charges. See those covered services for details.	$40 copay, deductible waived	Deductible, then 50% coinsurance
• Other outpatient professional and facility services	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Mental Health, Behavioral Health and Substance Abuse		
• Office or home visits	$40 copay, deductible waived	Deductible, then 50% coinsurance
• Other outpatient professional and facility services	20% coinsurance, deductible waived	Deductible, then 50% coinsurance
• Inpatient and residential services	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Maternity and Newborn Care Prenatal, postnatal, delivery, and inpatient care. See also ***Diagnostic Lab, X-ray and Imaging***. For specialty care see ***Office and Clinic Visits***.	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Home Health Care	Deductible, then 20%	Deductible, then 50% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
Limited to 130 visits per calendar year	coinsurance	
Hospice Care • Home visits (not subject to the Home Health Care visit limit) • Respite care, inpatient or outpatient (limited to 14 days lifetime)	Deductible, then 20% coinsurance Deductible, then 20% coinsurance	Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Habilitation Therapy Neuropsychological testing to diagnose is not subject to any maximum. See ***Mental Health, Behavioral Health and Substance Abuse*** for therapies provided for mental health conditions such as autism. Habilitation Therapy includes neurodevelopmental therapy. • Inpatient (limited to 30 days per calendar year) • Outpatient (limited to 25 visits per calendar year)	Deductible, then 20% coinsurance $40 copay, deductible waived	Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Rehabilitation Therapy See ***Mental Health, Behavioral Health and Substance Abuse*** for therapies provided for mental health conditions such as autism. • Inpatient (limited to 30 days per calendar year) • Outpatient (limited to 25 visits per calendar year)	Deductible, then 20% coinsurance $40 copay, deductible waived	Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Skilled Nursing Facility and Care • Skilled nursing facility care limited to 60 days per calendar year • Skilled nursing care in the long-term care facility care limited to 60 days per calendar year	Deductible, then 20% coinsurance Deductible, then 20% coinsurance	Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics Shoe inserts and orthopedic shoes limited to $300 per calendar year, except when diabetes-related. Sales tax, shipping and handling costs apply to any limit if billed and paid separately.	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
OTHER COVERED SERVICES		
Acupuncture • Acupuncture treatment limited to 12 visits per calendar year, except for chemical dependency/substance abuse treatment • Office visit with an acupuncturist. If an acupuncturist performs evaluation and management services with an acupuncture service, you only pay the higher copay.	$10 copay, deductible waived $40 copay, deductible waived	Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Allergy Testing and Treatment		

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
• Office visits • Other professional and facility services	$40 copay, deductible waived Deductible, then 20% coinsurance	Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Chemotherapy and Radiation Therapy • Office visits • Other professional and facility services	 $40 copay, deductible waived Deductible, then 20% coinsurance	 Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Clinical Trials	Covered as any other service	Covered as any other service
Dental Injuries	Covered as any other service	Covered as any other service
Dental Anesthesia When medically necessary	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Dialysis Dialysis for permanent kidney failure. See ***Dialysis*** benefit for details. See ***Allowed Amount*** for more information. • During Medicare's waiting period • After Medicare's waiting period	 Deductible, then 20% coinsurance No charge	 Deductible, then 50% coinsurance 0% coinsurance, deductible waived
Foot Care Routine care that is medically necessary • Office visits • Other professional and facility services	 See Office and Clinic Visits Deductible, then 20% coinsurance	 Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Hearing • Routine exams limited to one every 2-calendar year period. If hearing tests done in a separate visit, the office visit copay does not apply to the testing. • Hearing hardware, limited to $1,000 every 3-calendar year period.	 $40 copay, deductible waived No Charge	 $40 copay, deductible waived No Charge
Infusion Therapy • Office visits • Other professional and facility services	 $40 copay, deductible waived Deductible, then 20% coinsurance	 Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Mastectomy and Breast Reconstruction	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Medical Foods Including phenylketonuria (PKU)	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Non-Preventive Nutritional Therapy See ***Preventive Care*** for details of when in-network nutritional therapy is covered as preventive	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Spinal or Other Manipulative Treatment • Spinal or other manipulation treatment	 $10 copay, deductible waived	 Deductible, then 50% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
limited to 10 visits per calendar year • Office visit with a chiropractor. If a chiropractor performs evaluation and management services with a manipulation service, you only pay the higher copay	$40 copay, deductible waived	Deductible, then 50% coinsurance
Temporomandibular Joint (TMJ) Disorders		
• Office visits with your PCP	No charge first 2 visits per calendar year, then $10 copay, deductible waived	Deductible, then 50% coinsurance
• All other office and clinic visits	$40 copay, deductible waived	Deductible, then 50% coinsurance
• Other professional and facility services	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Therapeutic Injections		
• Office visits with your PCP	No charge first 2 visits per calendar year, then $10 copay, deductible waived	Deductible, then 50% coinsurance
• All other office and clinic visits	$40 copay, deductible waived	Deductible, then 50% coinsurance
• Other professional and facility services	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Transplants*		
• Office visits	$40 copay, deductible waived	Not covered*
• Inpatient facility fees	Deductible, then 20% coinsurance	Not covered*
• Other professional and facility services, including donor search and harvest expenses	Deductible, then 20% coinsurance	Not covered*
• Travel and lodging. $5,000 limit per transplant. **All approved transplant centers covered at in-network benefit level.*	Deductible, then 0% coinsurance	In-network deductible, then 0% coinsurance

IMPORTANT PLAN INFORMATION

This plan is a Preferred Provider Plan (PPO). Your plan provides you benefits for covered services from providers within the Heritage Signature network in Washington. In Alaska your network includes any provider that has signed a contract with Blue Cross Blue Shield of Alaska. You have access to one of the many providers included in our network of providers for covered services included in your plan without referral. Please see ***How Providers Affect Your Costs*** for more information. You also have access to facilities, emergency rooms, surgical centers, equipment vendors or pharmacies providing covered services throughout the United States and wherever you may travel.

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.

Primary Care Office Visits

You can receive the lower copay amount on primary care office visit copays by selecting an in-network provider as your Primary Care Provider (PCP) and telling us the name of the PCP any time prior to an office visit. Your PCP must be in the network and be one of the following provider types:

- Family practice physician
- General practice provider
- Geriatric practice provider
- Gynecologist
- Internist
- Naturopath
- Nurse practitioner
- Obstetrician
- Pediatrician
- Physician Assistant

We encourage you to select a PCP at the time you enroll in this plan. If you have difficulty locating an available PCP, contact us and we will assign you to one of the provider types listed above who is accepting new patients. This provider will be your PCP, unless you decide to change to another provider. If your PCP is part of a group practice, you can see any provider type listed above in that practice, and receive the PCP office visit copay.

You can change your PCP selection at any time by contacting us.

Please call Customer Service for more information about selecting a PCP and to provide us with your selection. Urgent care, telehealth, preventive and specialty visits are not included. All other covered services provided by your selected PCP during the primary care office visit are subject to standard cost shares. For example, if you select a PCP and see that PCP for a cut that needs stitches, you will pay the lower copay amount for the office visit and will pay your plan's deductible and/or coinsurance for the stitching procedure. If you do not select a PCP, your office visit copay will be the higher copay amount.

See the ***Summary of Your Costs*** and ***Covered Services*** for details.

This plan complies with state and federal regulations about diabetes medical treatment coverage. Please see the ***Preventive Care***, ***Prescription Drugs***, ***Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics***, and the ***Foot Care*** benefits.

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for certain covered services and supplies before this plan provides benefits. If an out-of-network provider is covered at the in-network level as described below in ***How Providers Affect Your Costs,*** the in-network deductible applies. See the ***Summary of Your Costs*** for your deductible amounts.

Individual Deductible

This plan includes an individual deductible when you see in-network providers and a separate individual deductible when you see out-of-network providers. After you pay this amount, this plan will begin paying for your covered services.

See the ***Summary of Your Costs*** for your individual deductible amount.

Family Deductible

This plan includes a family deductible when you see in-network providers and a separate family deductible when you see out-of-network providers.

The family deductible is satisfied when two or more covered family members' allowed amounts for covered services for that calendar year total and meet the family deductible amount. One member may not contribute more than the individual deductible amount. This type of deductible is called "embedded".

Any amounts you pay for non-covered services, copays or amounts in excess of the allowed amount do not count toward the deductible.

See the ***Summary of Your Costs*** for your family deductible amount.

Deductibles are subject to the following:

- Deductibles add up during a calendar year and renew each year on January 1

- There is no carry over provision. Amounts credited to your deductible during the current calendar year will not carry forward to the next calendar year deductible
- Amounts credited to the deductible will not exceed the allowed amount
- Amounts credited toward the deductible do not add to benefits with an annual dollar maximum
- Amounts credited toward the deductible accrue to benefits with visit limits

Amounts that don't accrue toward the deductible are:

- Amounts that exceed the allowed amount
- Charges for excluded services
- Copays are not applied to the deductible

COPAYS

A copay is a dollar amount that you are responsible for paying to a healthcare provider for certain covered services.

See the ***Summary of Your Costs*** for your copay amounts.

COINSURANCE

Coinsurance is the percentage of the allowed amount for a covered service that you are responsible to pay when you receive covered services.

See the ***Summary of Your Costs*** for your coinsurance amounts.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is a limit on how much you pay each calendar year. After you meet the out-of-pocket maximum this plan pays 100% of the allowed amount for the rest of the calendar year. See the ***Summary of Your Costs*** for further detail.

Expenses that do not apply to the out-of-pocket maximum include:

- Charges above the allowed amount
- Services above any benefit maximum limit or durational limit
- Services not covered by this plan
- Services from out-of-network providers
- Covered services that say they do not apply to the out-of-pocket maximum on the ***Summary of Your Costs***

ALLOWED AMOUNT

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply. The allowed amount is described below.

In-Network

The allowed amount is the fee that we have negotiated with providers who have signed contracts with us and are in your provider network. See the ***Summary of Your Costs*** for the name of your provider network.

Out-of-Network

For contracted providers the allowed amount is the fee that we have negotiated with providers who have signed contracts with us.

For non-contracted providers the allowed amount is the least of the following (unless a different amount is required under applicable law or agreement):

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges

There is one exception. The allowed amount for emergency care by a non-contracted ambulance is always billed charges.

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

Pediatric Dental Services

In-Network Providers

The allowed amount is the fee that we have negotiated with our Dental Choice network providers.

Out-of-Network Providers

The allowed amount in no case be higher than the 90th percentile of provider fees in that geographic area.

Dialysis Due To End Stage Renal Disease

Providers Who Have Agreements With Us Or Other Blue Cross Blue Shield Licensees

The allowed amount is the amount explained above in this definition.

Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The amount we pay for dialysis during Medicare's waiting period will be no less than a comparable provider that has a contracting agreement with us or another Blue Cross Blue Shield Licensee and no more than 90% of billed charges.

The amount we pay for dialysis after Medicare's waiting period is 125% of Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

See ***Dialysis*** for more details.

Emergency Care

Consistent with the requirements of the Affordable Care Act the allowed amount will be the greater of the following:

- The median amount in-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 out-of-network providers

In addition to your deductible, copays and coinsurance, you will be responsible for charges received from out-of-network providers above the allowed amount.

Note: Non-contracted ambulances are always paid based on billed charges.

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

HOW PROVIDERS AFFECT YOUR COSTS

MEDICAL SERVICES

This plan is a Preferred Provider Plan (PPO). This means that your plan provides you benefits for covered services from providers of your choice. You have access to one of the many providers included in our Heritage Signature network. In Alaska your network includes any provider that has signed a contract with Blue Cross Blue Shield of Alaska. You also have access to qualified practitioners, facilities, emergency rooms, surgical centers, equipment vendors or pharmacies providing covered services throughout the United States and wherever you may travel. See ***Out-of-Area Care*** below. Hospitals, physicians and other providers in these networks are called "in-network providers."

A list of in-network providers is available in our Heritage Signature provider directory. These providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you.

The provider directory also shows which providers you can select as your PCP. You can receive the lower copay amount on primary care office visit copays by selecting a provider as your Primary Care Provider (PCP) and telling us the name of the PCP any time prior to an office visit. If you are having difficulty choosing an available PCP, contact us and we will assign a PCP to you. See ***Primary Care Office Visits*** for more information.

We update this directory regularly but it is subject to change. We suggest that you call us for current information and to verify that your provider, their office location or provider group is included in the Heritage Signature network before you receive services.

The Heritage Signature provider directory is available any time on our website at premera.com. You may also request a copy of this directory by calling Customer Service at the number located on the back cover or on your Premera ID card.

In-Network Providers

In-network providers are networks of hospitals, physicians and other providers that are part of our Heritage Signature network in Washington, any provider that has signed a contract with Blue Cross Blue Shield of Alaska in Alaska, or a Host Blue's provider network. These providers provide medical services at a negotiated fee. This fee is the allowed amount for in-network providers.

When you receive covered services from an in-network provider your medical bills will be reimbursed at a higher percentage (the in-network provider benefit level). In-network providers will not charge more than the allowed amount. This means that your portion of the charges for covered services will be lower.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network provider at the in-network benefit level. See ***Prior Authorization*** for details.

Out-of-Network Providers

Out-of-network providers are providers that are not part of your network. Your bills will be reimbursed at the lower percentage (the out-of-network benefit level) and the provider may bill you for charges above the allowed amount. You may also be required to submit the claim yourself. See ***Sending Us a Claim*** for details.

- **Contracted providers.** In some cases, an out-of-network provider may have a contract with us, but is not part of your network. Even though your bills will be reimbursed at the lower percentage (the out-of-network benefit level), contracted providers will not bill you for the amount above the allowed amount for a covered service.
- **Non-contracted providers.** Out-of-network non-contracted providers do not have a contract with us or with any of the other networks used by this plan. These providers will bill you the amount above the allowed amount for a covered service.

In-Network Benefits for Out-of-Network Providers

The following covered services and supplies provided by out-of-network providers will always be covered at the in-network level of benefits (based on the out-of-network allowed amount):

- 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 an out-of-network provider will be reimbursed on the same basis as a network provider. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowed amount.
- Services from certain categories of providers to which provider contracts are not offered. These types of providers are generally not listed in the provider directory.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with us, if you were admitted to that hospital by an in-network provider who doesn't have admitting privileges at an in-network hospital.
- Covered services received from providers located outside the United States.

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

PEDIATRIC DENTAL SERVICES

In-Network Providers

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.

You receive the highest level of coverage when you receive services from Dental Choice Network providers. You have access to these network providers wherever you are in the United States.

When you receive services from Dental Choice Network providers, your claims will be submitted directly to us and available benefits will be paid directly to the dental care provider. Dental Choice Network providers agree to accept our allowed amount as payment in full.

You're responsible only for your in-network cost shares, and charges for non-covered services. See the ***Summary of Your Costs*** for cost share amounts.

To locate a Dental Choice Network provider wherever you need services, please refer to our website or contact Customer Service. You'll find this information on the back cover.

Out-of-Network Providers

Out-of-network providers are providers that are not part of our Dental Choice Network. Your bills will be reimbursed at the lower percentage (the out-of-network benefit level) and the provider will bill you for charges above the allowed amount. You may also be required to submit the claim yourself. See ***Sending Us a Claim*** for details.

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 and to help us identify admissions that might benefit from case management.

PRIOR AUTHORIZATION

Your coverage for some services depends on whether the service is approved through the pre-authorization process.

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 ***Complaints and Appeals*** or call us.

There are three situations where prior authorization is required:

- Before you receive certain medical services and drugs, or prescription drugs
- Before you schedule a planned admission to certain inpatient facilities
- When you want to receive the higher benefit level for services you received from an out-of-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 website at premera.com. Before you receive services, we suggest that you review the list of services requiring prior authorization.

Services From Contracted Providers: Providers that have a contract with us are responsible to get prior authorization. Your provider can call us at the number listed on your ID card to request a prior authorization.

Services from Non-Contracted Providers: It is your responsibility to get prior authorization for any of the services on the Prior Authorization list when you see an out-of-network provider who does not have a contract with us. You or your provider can call us at the number listed on your ID card to request a prior authorization.

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 the all 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 do not receive the services within that time, you will have to ask us for another prior authorization.

Prior Authorization Penalty

For Services from In-Network and Contracted Providers

Providers that have contracts with us 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-Contracted Providers

It is your responsibility to get prior authorization for any services on the Prior Authorization list when you see a provider that does not have a contract with us. If you do not get prior authorization, the services will not be covered. The provider can bill you and you will have to pay the total cost for the services. Your costs for this penalty do not count toward your plan deductibles and out-of-pocket maximum.

Exceptions: The following services are not subject to this prior authorization requirement, but they have separate requirements:

- Emergency hospital admissions, including admissions for drug or alcohol detoxification. They do not require prior authorization, but you must notify us as soon as reasonably possible.

  If you are admitted to an out-of network hospital due an emergency condition, those services are always covered under your in-network cost share. We will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital. If you chose to remain at the out-of-network hospital after you are stable to transfer, coverage will revert to the out-of network benefit. We provide benefits for services based on our allowed amount. If the hospital is non-contracted, you may be billed for charges over the allowed amount.
- Childbirth admission to a hospital, or admissions for newborns who need medical care at birth. They do not require prior authorization, but you must notify us as soon as reasonably possible. Admissions to an out-of-network hospital will be covered at the out-of-network cost share unless the admission was an emergency.

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 us to provide benefits. Your provider can ask for a prior authorization by faxing a prior authorization form to us. This form is on the pharmacy section of our website at premera.com. See the specific list of prescription drugs requiring prior authorization on our website on premera.com. 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.

You can buy the prescription drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See ***Sending Us a Claim*** for details.

Services from Out-of-Network Providers

This plan provides benefits for non-emergency care from out-of-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 an out-of-network provider. You or your provider may request a prior authorization for the in-network benefit before you see the out-of-network provider.

The prior authorization request must include the following:

- A statement that the out-of-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 we approve the request, the services will be covered at the in-network cost share. In addition to the cost shares, you will be required to pay any amounts over the allowed amount if the provider does not have a contracting agreement with us.

CLINICAL REVIEW

Premera 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 website. You or your provider may review them at 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 reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigative. A decision by Premera following this review may be appealed in the manner described in ***Complaints and Appeals***. When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

PERSONAL HEALTH SUPPORT PROGRAMS

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

Your participation in a treatment plan through our personal health support programs is voluntary. To learn more about the programs, contact Customer Service at the number listed on your Premera Blue Cross ID card.

CONTINUITY OF CARE

You may be able to continue to receive covered services from a provider for a limited period of time at the in-network benefit level after the provider ends his/her contract with Premera. To be eligible for continuity of care you must be covered under this plan, in an active treatment plan and receiving covered services from an in-network provider at the time the provider ends his/her contract with Premera. The treatment must be medically necessary and you and this provider agree that it is necessary for you to maintain continuity of care.

We will not provide continuity of care if your provider:

- Will not accept the reimbursement rate applicable at the time the provider contract terminates
- Retired
- Died
- No longer holds an active license
- Relocates out of the service area
- Goes on sabbatical
- Is prevented from continuing to care for patients because of other circumstances
- Terminates the contractual relationship in accordance with provisions of contract relating to quality of care and exhausts his/her contractual appeal rights

We will not provide continuity of care if you are no longer covered under this plan.

We will notify you no later than 10 days after your provider's Premera contract ends if we reasonably know that you are under an active treatment plan. If we learn that you are under an active treatment plan after your provider's contract termination date, we will notify you no later than the 10th day after we become aware of this fact.

You can call or send your request to receive continuity of care to Care Management at the address or fax number shown on the back cover.

Duration of Continuity of Care

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

- The 90th day after we notified you that your Primary Care Provider (PCP)'s contract ended
- The 90th day after we notified you that your provider's contract ended, or the date your request for continuity of care was received or approved, whichever is earlier
- The day after you complete the active course of treatment entitling you to continuity of care
- If you are pregnant, and become eligible for continuity of care after commencement of the second trimester of the pregnancy, you will receive continuity of care
- As long as you continue under an active course of treatment, but no later than the 90th day after we notified you that your provider's contract ended, or

the date your request for continuity of care was received or approved, whichever is earlier.

When continuity of care terminates, you may continue to receive services from this same provider, however, we will pay benefits at the out-of-network benefit level subject to the allowed amount. Please refer to the ***How Providers Affect Your Costs*** for an illustration about benefit payments. If we deny your request for continuity of care, you may request an appeal of the denial. Please refer to ***Complaints and Appeals*** for information on how to submit a complaint review request.

COVERED SERVICES

This section describes the services this plan covers. Covered services means medically necessary services (see ***Definitions***) and specified preventive care services you receive when you are covered for that benefit. This plan provides benefits for covered services only if all of the following are true when you receive the services:

- The reason for the services is to prevent, diagnose or treat a covered illness or injury
- The service takes place in a medically necessary setting. This plan covers inpatient care only when you cannot get the services in a less intensive setting.
- The service is not excluded
- The provider is working within the scope of their license or certification

This plan may exclude or limit benefits for some services. See the specific benefits in this section and ***Exclusions*** for details.

Benefits for covered services are subject to the following:

- Copays
- Deductibles
- Coinsurance
- Benefit limits
- Prior Authorization. Some services must be authorized in writing before you get them. These services are identified in this section. For more information see ***Prior Authorization***.
- Medical and payment policies. The plan has policies used to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigative status for specific procedure, 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 premera.com or by calling Customer Service.

If you have any questions regarding your benefits and how to use them, call Customer Service at the number listed.

COMMON MEDICAL SERVICES

The services listed in this section are covered as shown on the ***Summary of Your Costs***. Please see the summary for your copays, deductible, coinsurance, benefit limits and if out-of-network services are covered.

Office and Clinic Visits

This plan covers professional office, clinic and home visits. The visits can be for examination, consultation and diagnosis of an illness or injury, including second opinions, for any covered medical diagnosis or treatment plan. You may have to pay a separate copay or coinsurance for other services you get during a visit. This includes services such as x-rays, lab work, therapeutic injections, associated supplies and durable medical equipment, facility fees and office surgeries. Some outpatient services you get from a specialist must be prior authorized. See ***Prior Authorization*** for details. See ***Urgent Care Centers*** for care provided in an office or clinic urgent care center. See ***Preventive Care*** for coverage of preventive services.

- **Office visits with your PCP** are covered as shown in the ***Summary of Your Costs***. See ***Important Plan Information*** for details about how to select a PCP.
- **Telehealth services** are covered as shown in the ***Summary of Your Costs***.
- **Office visits for women's health** are covered as shown in the ***Summary of Your Costs***.
- **Consultations with a pharmacist** are covered as shown in the ***Summary of Your Costs***.
- **All other office and clinic visits** are covered as shown in the ***Summary of Your Costs***.

Home Based Chronic Care

Evaluation and management services of chronic conditions provided by a doctor or nurse practitioner in your place of residence. This benefit does not include other services such as x-rays, lab, and durable medical supplies charges. For information about those services see ***Diagnostic Lab, X-ray and Imaging*** and ***Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics*** for details. If you are seen at an office or clinic, see ***Office and Clinic Visits*** above.

Preventive Care

Preventive care is as specific set of evidence-based

services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies.

Please go to this government website for more information:
https://www.healthcare.gov/coverage/preventive-care-benefits/

Preventive services provided by in-network providers are covered in full. But, they have limits on how often you should get them. These limits are often based on your age and gender. After a limit has been exceeded, these services are not covered in full and may require you to pay more out-of-pocket costs.

Some of the services your doctor does during a routine exam may not meet preventive guidelines. These services are then covered the same as any other similar medical service and are not covered in full.

For example:

During your preventive exam, your doctor may find an issue or problem that requires further testing or screening for a proper diagnosis to be made. Also, if you have a chronic disease, your doctor may check your condition with tests. These types of screenings and tests help to diagnose or monitor your illness and would not be covered under your preventive benefits. They would require you to pay a greater share of the costs.

You can also get a complete list of the preventive care services with the limits on our website at premera.com or call us for a list. This list may be changed as required by state and federal preventive guidelines. The list will include website addresses where you can see current federal preventive guidelines.

The plan covers the following as preventive services:

- Covered preventive services include those with an Services with an “A” or “B” rating by the United States Preventive Task Force (USPTF); immunizations recommended by the Centers for Disease Control and Prevention and as required by state law; and preventive care and screening recommended by the Health Resources and Services Administration (HRSA).
- Depression screening, including screening for adults and pregnant/postpartum women
- Routine exams and well-baby care. Included are exams for school, sports and employment
- Women’s preventive exams. Includes pelvic exams, pap smear and clinical breast exams.
- Screening mammograms. See ***Diagnostic Lab, X-ray and Imaging*** for mammograms needed because of a medical condition.
- Pregnant women’s services such as breast feeding counseling before and after delivery and maternity diagnostic screening and diabetes supplies
- Electric breast pumps and supplies. Includes the purchase of a non-hospital grade breast pump or rental of a hospital grade breast pump. The cost of the rental cannot be more than the purchase price. For electric breast pumps and supplies purchased at a retail location you will need to pay out of pocket and submit a claim for reimbursement. See ***Sending Us a Claim*** for instructions.
- BRCA genetic testing for women at risk for certain breast cancers
- Professional services to prevent falling for members who are 65 years and older and have a history of falling or mobility issues
- Prostate cancer screening. Includes digital rectal exams and prostate-specific antigen (PSA) tests.
- Colon cancer screening for high risk individuals under 50 years of age, all individuals 50 years of age or older. Includes pre-colonoscopy consultations, exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Removal and pathology (biopsy) related to polyps found during a screening procedure are covered as part of the preventive screening. Includes anesthesia your doctor considers medically appropriate for you.
- Outpatient lab and radiology for preventive screening and tests
- Diabetes screening
- Routine immunizations and vaccinations as recommended by your physician. You can also get flu shots, flu mist, and immunizations for shingles, pneumonia and pertussis at a pharmacy or other center. If you use an out-of-network provider for seasonal and travel immunizations you may need to pay out of pocket and submit a claim for reimbursement. See ***Sending Us a Claim*** for instructions.
- Obesity screening and counseling for weight loss for children age six and older who are considered obese and for adults with body mass index of 30 kg/meter squared or higher
- Health education and training for covered conditions such as diabetes, high cholesterol and obesity. Includes outpatient self-management programs, training, classes and instruction.
- Nutritional therapy. Includes outpatient visits with a physician, nurse, pharmacist or registered dietitians. The purpose of the therapy must be to manage a chronic disease or condition such as diabetes, high cholesterol and obesity. The

number of therapy visits that are covered as preventive depends on your medical needs.

- Preventive drugs required by federal law. See ***Prescription Drugs***.
- Approved tobacco use cessation programs recommended by your physician. After you have completed the program, please provide us with proof of payment and a completed reimbursement form. You can get a reimbursement form on our website at premera.com. See ***Prescription Drugs*** for covered drug benefits.

The Preventive Care benefit does not cover:

- Gym memberships or exercise classes and programs
- Inpatient newborn exams while the child is in the hospital following birth. See ***Maternity and Newborns*** for those covered services.
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations

Diagnostic Lab, X-ray and Imaging

This plan covers diagnostic medical tests that help find or identify diseases. Covered services include interpreting these tests for covered medical conditions. Some diagnostic tests, such as MRA, MRI, CT and echocardiograms require prior authorization. See ***Prior Authorization*** for details.

Preventive Care Screening and Tests

Preventive care screening and tests are covered in full when provided by an in-network provider. "Preventive care" is as specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies. For more information about what services are covered as preventive see ***Preventive Care***.

Basic Diagnostic Lab, X-ray and Imaging

Basic diagnostic lab, x-ray and imaging services that do not meet the preventive guidelines include but are not limited to:

- Barium enema
- Bone density screening for osteoporosis
- Cardiac testing, including pulmonary function studies
- Diagnostic imaging like x-rays and EKGs
- Lab services
- Lab, x-ray and imaging services to establish a cause of infertility
- Mammograms for a medical condition
- Neurological and neuromuscular tests
- Pathology tests
- Standard ultrasounds

Major Diagnostic X-ray and Imaging

Major diagnostic x-ray and imaging services include:

- Computed Tomography (CT) scan
- High technology ultrasounds
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan

The diagnostic lab, x-ray and imaging benefit does not cover:

- Diagnostic services from an inpatient facility, an outpatient facility, or emergency room that are billed with other hospital or emergency room services. These services are covered under inpatient, outpatient or emergency room benefits.
- Allergy tests. These services are covered under the ***Allergy Testing and Treatment*** benefit.

Pediatric Care

This plan covers pediatric vision services until the end of the month of a member's 19th birthday, when all eligibility requirements are met. These services are covered as stated on the ***Summary of Your Costs***.

Pediatric Vision Services

Coverage for routine eye exams and glasses includes the following:

- Vision exams, including dilation and with refraction, by an ophthalmologist or an optometrist. A vision exam may consist of external and ophthalmoscopic examination, determination of the best corrected visual acuity, determination of the refractive state, gross visual fields, basic sensorimotor examination and glaucoma screening.
- Glasses, frames and lenses
- Contact lenses instead of glasses
- Contact lenses or glasses required for medical reasons
- Comprehensive low vision evaluation and follow up visits
- Low vision devices, high power spectacles, magnifiers and telescopes when medically necessary

Pediatric Dental Services

This plan covers pediatric dental services until the end of the month of a member's 19th birthday, when all eligibility requirements are met.

Pediatric dental services are covered as stated on the ***Summary of Your Costs, Pediatric Dental***

Services section.

Pediatric dental services are covered limited as follows:

- They must be dentally necessary (see ***Definitions***)
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (D.M.D. or D.D.S.) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her license or certification, as allowed by law.
- They must not be excluded from coverage under this benefit

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. These materials will be requested directly from your dental care provider. If we're unable to obtain necessary materials, we'll provide benefits only for those dental services we can verify as covered.

You can ask for an ***Estimate of Benefits***. An ***Estimate of Benefits*** verifies, for the dental care provider and yourself, your eligibility and benefits. It may also clarify, before services are rendered, treatment that isn't covered in whole or in part. This can protect you from unexpected out-of-pocket expenses.

An ***Estimate of Benefits*** isn't required in order for you to receive your dental benefits. However, we suggest that your dental care provider submit an estimate to us for any proposed dental services in which you are concerned about your out-of-pocket expenses.

Our ***Estimate of Benefits*** is not a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time services are rendered. Please see the back cover for the address and fax for an ***Estimate of Benefits***, or call Customer Service.

Alternative Benefits

To determine benefits available under this plan, we consider alternative procedures or services with different fees that are consistent with acceptable standards of dental practice. In all cases where there's an alternative course of treatment that's less costly, we'll only provide benefits for the treatment with the lesser fee. If you and your dental care provider choose a more costly treatment, you're responsible for additional charges beyond those for the less costly alternative treatment.

Dental Care Services for Congenital Anomalies

This plan covers dental services when impairment is related to or caused by a congenital disease or anomaly from the moment of birth for a child afflicted with a congenital disease or anomaly.

Dental care coverage includes the following:

Class I – Diagnostic and Preventive Services

- Routine comprehensive and periodic oral evaluations are limited to 2 visits per calendar year. (See definition of ***Comprehensive Oral Evaluation***)
- Pre-diagnostic visual oral screenings or assessments are limited to 2 visits per calendar year. (See definition of ***Visual Oral Screenings or Assessments***)
- X-rays include:
  - A complete (full-mouth) series x-ray once every 36 months
  - A panoramic x-ray once every 36 months
  - Bitewing x-rays up to a maximum of 4 are limited to 2 per calendar year
  - Periapical x-rays
- Prophylaxis (cleaning) is limited to 2 per calendar year
- Fluoride treatment (including fluoride varnish) is limited to 3 treatments per calendar year
- Oral hygiene instruction is limited to 2 times per calendar year for ages 8 and under if not performed on the same day as prophylaxis (cleaning)
- Sealants are limited to permanent bicuspids and molars only
- Fixed space maintainers are covered for members age 12 years and younger only when designed to preserve space for permanent teeth
  - Re-cement or re-bond space maintainers is covered for members age 12 years and younger
  - Removal of fixed space maintainer is covered when removed by a different provider
  - Replacement of space maintainers will be covered only when dentally necessary
  - Occlusal intraoral x-rays are limited to once every 24 months

Class II – Basic Services

- Limited oral evaluations – problem focused or emergent. (See definition of ***Limited Oral Evaluation – Problem Focused)***
- Other x-rays include:
  - Cephalometric film is limited to once every 24 months
  - Oral and facial photographic images and other non-routine x-rays are subject to review for dental necessity on a case by case basis
- Fillings, consisting of amalgam and resin-based

composite on any tooth surface are limited to once every 24 months. Multiple restorations on any tooth surface will be considered one surface regardless of the number or combination of restorations.

- Prefabricated stainless steel crowns including those made with porcelain, ceramic or resin material are limited to once every 36 months on permanent or primary teeth
- Repair to complete and partial dentures is limited to once in a 12 month period
- Recement or rebound permanent crown or fixed partial denture is covered for members age 12 years and older
- Repair to crowns (indirect) is limited to once per tooth per lifetime
- Pulp vitality tests
- Non-surgical periodontics include:
  - Full mouth debridement
  - Periodontal maintenance following periodontal therapy is covered once per quadrant for members age 13 and older and is limited to 1 per calendar year
- Simple extractions
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- House/extended care facility call is limited to 2 per facility per day, when medically or dentally necessary
- Behavior management (behavior guidance techniques used by dental provider)

Class III – Major Services

- Diagnostic casts or study models
- Crowns (indirect) and crown build-ups including pins are covered for members age 12 years and older, limited to permanent anterior teeth only and limited to once every five years when there is significant loss of clinical crown and no other dentally appropriate restoration will restore function
- Endodontics Services include:
  - Direct pulp cap
  - Therapeutic pulpotomy is limited to primary teeth only
  - Pulpal debridement is limited to permanent teeth only
  - Pulpal therapy (resorbable filling) is limited to primary teeth only
  - Endodontic treatment is limited to permanent anterior, bicuspid, and molar teeth excluding teeth 1, 16, 17, and 32 teeth only
  - Endodontic retreatment includes the removal of post, pin, and old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material and is limited to permanent anterior, bicuspid, and molar teeth excluding teeth 1, 16, 17, and 32. Endodontic retreatment provided by the original treating provider or clinic is subject to review for medical or dental necessity.
  - Apexification for apical closures is limited to anterior permanent teeth only. Apexification is limited to the initial visit and three medication replacements.
  - Apicoectomy and retrograde filling is limited to anterior teeth only
- Periodontal scaling and root planing is covered for members age 13 years and older and is limited to once per quadrant every 24 months
- Surgical periodontics include:
  - Gingivectomy and gingivoplasty is limited to once every 3 years
  - Osseous surgery including flap entry and closure, and mucogingival surgery is limited to once every 5 years
- Initial placement of bridges (fixed partial dentures). Replacement is limited to once every 7 years after the original was placed.
- Initial placement of complete dentures, including overdentures is covered when the denture cannot be made serviceable by a less costly procedure
  - Includes three-month post-delivery care (e.g., adjustments, soft relines, and repairs) after placement
  - Replacement of complete denture or overdenture is limited to 1 per lifetime and at least 5 years after the original was placed
- Initial placement of resin base partial dentures are covered when one or more anterior teeth are missing or four or more posterior teeth (excluding third molars) per arch and the remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis
  - Includes three months post-delivery care (e.g., adjustments, soft relines, and repairs) after placement
  - Replacement of resin partials is limited to once every three years
- Denture rebase and reline is limited to once in a three year period when performed at least six months after placement
- Denture adjustment, excluding three-month post-delivery care
- Dental implant crown and implant abutment related procedures limited to 1 every 7 years
- Repair of implant supported prosthesis or abutment, limited to one per tooth per member

lifetime

- Other oral surgery related to the teeth and supporting structures in a dental office including:
  - Surgical extraction and removal of erupted or impacted tooth
  - Biopsy of oral tissue, hard or soft
  - Removal of odontogenic cyst or tumor
  - Alveoplasty
  - Vestibuloplasty
  - Frenuloplasty/frenulectomy is covered for members age 6 and under
- Therapeutic parentera/therapeutic drugs such as antibiotics, steroids, and anti-inflammatory medication administered in a dental office
- Anesthesia in conjunction with covered services in a dental care provider's office includes:
  - General anesthesia, deep sedation or intravenous (conscious) sedation when necessary due to age, condition or degree of difficulty
  - Non intravenous conscious sedation
  - Nitrous oxide is limited to once per day
  - Local anesthesia and regional blocks are considered part of the global fee if billed with any covered service
- Treatment of post-surgical complications such as dry socket by a dental provider
- Hospital call including emergency care limited to 1 per day, when dentally necessary
- Occlusal guard (nightguard) is covered for bruxism and other occlusal factors when dentally necessary for members age 12 and over
- Medically necessary orthodontia services. This benefit includes braces and orthodontic retainer for specific malocclusions associated with:
  - Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
  - Craniofacial anomalies (Hemifacial Microsomia, Craniosynostosis syndromes, Arthrogryposis and Marfan syndrome)

  Orthodontic services are covered when medically necessary. Orthodontic services require prior authorization before services are received. See ***Prior Authorization*** section for details. To request a prior authorization, please contact our Customer Service Department.

The pediatric dental services benefit does not cover:

- Application of any type of desensitizing medicament
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Cleaning of appliances
- Coping
- Cosmetic services:
  - Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof
  - Cosmetic orthodontia
- Diagnostic tests and examinations including collection, preparation, analysis, viral culture, genetic and caries susceptibility tests, and adjunctive pre-diagnostic tests
- Diagnostic tomographic surveys, cone beam, MRI, ultrasound, 3-D imaging, and posterior-anterior or lateral skull and facial bone survey films
- Duplicate appliances
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Fabrication of an athletic mouthguard
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Home use products. Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.
- Inlay, onlay or gold foil restorations
- Labial veneers
- Implants. Dental implants and implant related services.
- Localized delivery of antimicrobial agents
- Increase of vertical dimension. Any service to increase or alter the vertical dimension.
- Indirect pulp caps
- Immediate dentures
- Multiple providers. Services provided by more than one dental care provider for the same dental procedure.
- Non-standard techniques. Techniques other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.
- Occlusion analysis and limited and complete occlusal adjustments
- Oral pathology laboratory including collection of tissue samples, cultures and specimens
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments, replacement of replaceable parts for semi-precision or precision attachments and personalization of appliances
- Provisional splinting
- Sedative filings
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this

plan (including services and supplies started before your effective date or after the date coverage ends)

- Surgical procedures including:
  - Incision and drainage of abscess-extra oral soft tissue
  - Radical resection of maxilla or mandible
  - Removal of non-odontogenic cyst, tumor or lesion
  - Surgical stent
  - Surgical procedures for isolation of a tooth with rubber dam
- Temporary, interim or provisional services for crowns, bridges or dentures
- Testing and treatment for mercury sensitivity or that are allergy-related
- Tobacco cessation and nutritional counseling for control of dental disease
- Tooth preparation, acid etching, all adhesives, and liners
- Tooth transplantation including re-implantation from one site to another and splinting and/or stabilization

Prescription Drugs

This plan uses a prescription drug formulary. **Please refer to your ID card for your prescription drug formulary.**

Some prescription drugs require prior authorization. See ***Prior Authorization*** for details.

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:

- 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 investigative drugs not otherwise approved for any indication by the FDA.

Prescription Drug Formulary

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

The formulary includes both generic and brand name drugs. Consult the Pharmacy Benefit Guide or RX Search tool listed on our web page, or contact Customer Service for a complete list of your plan's covered prescription drugs.

Drugs not included in the formulary are not covered by this plan.

Exceptions Request for Non-Formulary Drugs

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

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

Your provider must give us a written or oral statement providing a justification in support of the need for the non-formulary drug to treat your condition, including a statement that all covered formulary drugs on any tier will be (or have been) ineffective, and would not be as effective as the non-formulary drug, or would have adverse side effects. We will review your request and let you or your provider know within 72 hours in writing if it is approved. If approved, your cost will be as shown on the ***Summary of Your Costs*** for formulary generic and brand name drugs and will be covered for the duration of the prescription. If your request is not approved, the drug will not be covered.

Expedited Exceptions Request for Non-Formulary Drugs

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

External Review for Non-Formulary Drugs

If you disagree with our decision you may ask for an additional review through the plan's complaint and appeals process we will let you and your provider know the decision within 72 hours (24 hours in the case of an expedited review). See ***Complaints and Appeals*** for details.

Covered Prescription Drugs

- FDA approved formulary prescription drugs. Federal law requires a prescription for these drugs. They are known as "legend drugs."
- Compound drugs when the main drug ingredient is a covered prescription drug
- Oral drugs for controlling blood sugar levels, insulin and insulin pens
- Throw-away diabetic test supplies such as test strips, testing agents and lancets
- Drugs for shots you give yourself
- Needles, syringes and alcohol swabs you use for shots
- Glucagon emergency kits
- Inhalers, supplies and peak flow meters
- Drugs for nicotine dependency. Generic over-the-counter (OTC) also covered.
- Human growth hormone drugs when medically necessary
- Oral chemotherapy drugs
- Drugs associated with an emergency medical condition (including drugs from a foreign country)

Pharmacy Management

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

- A specific number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment
- Certain drugs for a specific diagnosis
- Certain drugs from certain pharmacies, or you may need to get prescriptions from an appropriate medical specialists or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first
- Drug synchronization, meaning when a member requests a new prescription to be filled and the cost sharing adjusted in compliance with state law

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

Dispensing Limits

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

Preventive Drugs

Benefits for certain preventive care prescription drugs will be as shown in the ***Summary of Your Costs*** when received from network pharmacies. Contact Customer Service or visit our web site to inquire about whether a drug is on our preventive care list.

You can get a list of covered preventive drugs by calling Customer Service. You can also get this by going to the preventive care list on our web page at premera.com.

Using In-network Pharmacies

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

If you do not show your Premera ID Card, you will be charged the full retail cost. Then you must send us your claim for reimbursement. Reimbursement is based on the allowed amount. See ***Sending Us a Claim*** for instructions.

This plan does not cover prescription drugs from out-

of-network pharmacies.

Specialty Pharmacy Programs

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

Specialty drugs are high-cost often self-administered injectable drugs. They are used to treat conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis or growth disorders (excluding idiopathic short stature without growth hormone deficiency). We contract with specific specialty pharmacies that specialize in these drugs.

To find our in-network specialty pharmacies. Visit the pharmacy section of our website at premera.com or call Customer Service for more information.

Diabetic Injectable Supplies

Whether injectable diabetic drug needles and syringes are purchased along with injectable diabetic drugs or separately, the deductible and applicable cost-share applies to all items. The deductible and applicable cost-share also applies to purchases of alcohol swabs, test strips, testing agents and lancets.

Oral Chemotherapy Medication

This benefit covers self-administered oral drugs when the medication is dispensed by a pharmacy. These drugs are covered as shown in the ***Summary of Your Costs***.

This benefit does not cover:

- Drugs and medicines that you can legally buy over the counter (OTC) without a prescription. OTC drugs are not covered even if you have a prescription. Examples include, but are not limited to, nonprescription drugs and vitamins, herbal or naturopathic medicines, and nutritional and dietary supplements such as infant formulas or protein supplements. This exclusion does not apply to OTC drugs that are required to be covered by state or federal law.
- Non-formulary drugs
- Drugs for cosmetic use such as for wrinkles
- Drugs to promote or stimulate hair growth
- Blood or blood derivatives. Please see ***Surgery Services*** for more information on blood and blood derivative coverage.
- Any prescription refill beyond the number of refills shown on the prescription or any refill after one year from the original prescription
- Replacement of lost or stolen drug
- Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and injectable medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones. See ***Infusion Therapy*** for covered infusion therapy services.
- Drugs dispensed for use in a healthcare facility or provider's office or take-home medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones.
- Immunizations. See ***Preventive Care***.
- Drugs to enhance fertility or to treat sexual dysfunction of organic origin, including impotence and decrease libido. This exclusion does not apply to sexual dysfunction diagnoses listed in Diagnostic and Statistical Manual (DSM).
- Weight management drugs
- Therapeutic devices or appliances. See ***Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics***.

Drug Discount Programs

Premera may receive drug rebates or discounts.

- Your benefit programs include per-claim rebates that Premera receives from its pharmacy benefit manager or other vendors. We consider these rebates when we set the subscription charges, or we credit them to administrative charges that we would otherwise pay. These rebates are not reflected in your allowed amount.
- We also may receive discounts from our pharmacy benefit manager. These discounts are reflected in your allowed amount. If the allowed amount for prescription drugs is higher than the price we pay after our discount, then Premera does one of two things with this difference:
  - We keep the difference and apply it to the cost of our operations and the prescription drug benefit program
  - We credit the difference to premium rates for the next benefit year

If your benefit includes a copay, coinsurance calculated as a percentage, or a deductible, the amount you pay and your account calculations are based on the allowed amount.

Your Right to Safe and Effective Pharmacy Services

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

Service. The phone numbers are shown on the back cover.

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

Questions and Answers about Your Prescription Drug Benefits

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

   Your prescription drug benefit uses a drug list. (This is sometimes referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the prescription drug formulary. This plan doesn't cover certain categories of drugs. These are listed above under "What's Not Covered." Non-formulary medications may be covered only on an exception basis for members meeting medical necessity criteria.

   Certain formulary drugs are subject to pre-dispensing medical necessity review. As part of this review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent medication.

   See ***Prior Authorization*** for details.

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

   The formulary is updated frequently throughout the year. See "Prescription Drug Formulary" above. If changes are made to the drug list prior to the quarterly update, you will receive a letter advising you of the change that may affect your cost share.

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. Provisions regarding substitution of some drugs are described above in question 1.

   You can appeal any decision you disagree with. Please see ***Complaints and Appeals***, or call our Customer Service department at the telephone numbers listed on the back cover 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, mail-order pharmacy or specialty pharmacy is described in the ***Summary of Your Costs***.

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

   Yes. You only receive benefits when you have your prescriptions filled by participating pharmacies. The majority of pharmacies in Washington are part of our pharmacy network.

   You can find a participating pharmacy near you by consulting your provider directory, or calling the Pharmacy Locator Line at the toll-free telephone number found on the back of your Premera Blue Cross ID card.

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" provision 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

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

Surgery Services

This plan covers inpatient and outpatient surgical services at a hospital or ambulatory surgical facility, surgical suite or provider's office. Some outpatient surgeries must be prior authorized before you have them. See ***Prior Authorization*** for details.

Covered services include:

- Anesthesia or sedation and postoperative care, as medically necessary

- Cornea transplants and skin grafts
- Cochlear implants
- Blood transfusion, including blood derivatives. Storage is covered only when medically necessary.
- Biopsies and scope insertion procedures such as endoscopies
- Colonoscopy and sigmoidoscopy services that do not meet the preventive guidelines. For more information about what services are covered as preventive see ***Preventive Care***.
- Facility fees
- Surgery to correct underlying medical cause of infertility. Please Note: Benefits are not provided for assisted reproduction techniques, or sterilization reversal.
- Surgical supplies
- Termination of pregnancy
- Reconstructive surgery that is needed because of an injury, infection or other illness
- The repair of a congenital anomaly
- Cosmetic surgery for correction of functional disorders
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes

This benefit does not cover:

- Breast reconstruction. See ***Mastectomy and Breast Reconstruction*** for those covered services.
- The use of an anesthesiologist for monitoring and administering general anesthesia for endoscopies, colonoscopies and sigmoidoscopies unless medically necessary when specific medical conditions and risk factors are present.
- Transplant services. See ***Transplants*** for details.

Emergency Room

This plan covers services you get in a hospital emergency room for an emergency medical condition. An emergency medical condition includes things such as heart attack, stroke, serious burn, chest pain, severe pain or bleeding that does not stop. You should call 911 or the emergency number for your local area. You can go to the nearest hospital emergency room that can take care of you. If it is possible, call your physician first and follow their instructions.

You do not need prior authorization for emergency room services. However, you must let us know if you are admitted to the hospital from the emergency room as soon as reasonably possible. See ***Prior Authorization*** for details.

Covered services include the following:

- The emergency room and the emergency room doctor
- Services used for emergency medical exams and for stabilizing a medical condition
- Outpatient tests billed by the emergency room and that you get with other emergency room services

Benefits are covered at the in-network cost share up to the allowed amount from any hospital emergency room. You pay any amounts over the allowed amount when you get services from non-contracted providers even if the hospital emergency room is in an in-network hospital. If you pay out of pocket for prescription medications associated with an emergency medical need, submit a claim to us for reimbursement. See ***Sending Us a Claim*** for instructions.

This benefit does not cover the inappropriate (non-emergency) use of an emergency room. This means services that could be delayed until you can be seen in your doctor's office. This could be for things like minor illnesses such as a cold, check-ups, follow-up visits and prescription drug requests.

Emergency Ambulance Services

This plan covers emergency ambulance services to the nearest facility that can treat your condition. The medical care you get during the trip is also covered. These services are covered only when any other type of transport would put your health or safety at risk. Covered services also include transport from one medical facility to another as needed for your condition. Transportation to your home is covered when medically necessary.

This plan covers ambulance services from licensed providers only and only for the member who needs transport. Payment for covered services will be paid to the ambulance provider or to both the ambulance provider and you.

Prior authorization is required for non-emergency ambulance services. See ***Prior Authorization*** for details.

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.

You may have to pay a separate copay or coinsurance for other services you get during a visit. This includes things such as x-rays, lab work, therapeutic injections and office surgeries. See those covered services for details.

If an urgent care visit is provided in a center located in a hospital, benefits may also be subject to the calendar year deductible and coinsurance related to facility fees charged by the hospital.

Hospital Services

This plan covers services you get in a hospital. At an in-network hospital, you may get services from doctors or other providers who are not in your network. When you get covered services from non-contracted providers, you pay any amounts over the allowed amount.

Inpatient Care

Covered services include:

- Room and board, general duty nursing and special diets
- Doctor services and visits
- Use of an intensive care or special care units
- Operating rooms, surgical supplies, anesthesia, drugs, blood, dressing, durable medical equipment and oxygen
- X-ray, lab and testing

Outpatient Care

Covered services include:

- Operating rooms, procedure rooms and recovery rooms
- Doctor services
- Anesthesia
- Services, medical supplies and drugs that the hospital provides for your use in the hospital
- Lab and testing services billed by the hospital and done with other hospital services

This benefit does not cover:

- Hospital stays that are only for testing, unless the tests cannot be done without inpatient hospital facilities, or your condition makes inpatient care medically necessary
- Any days of inpatient care beyond what is medically necessary to treat the condition

Mental Health, Behavioral Health and Substance Abuse

This plan covers mental health care and treatment for substance abuse disorder. This plan will also cover alcohol and drug services from a state-approved treatment program. When medically appropriate, services may be provided in your home. You must also get these services in the lowest cost type of setting that can give you the care you need. This plan will comply with federal mental health parity requirements.

Some services require prior authorization. See ***Prior Authorization*** for details.

Mental Health Care

This plan covers all of the following services:

- Inpatient, residential treatment and outpatient care to manage or reduce the effects of the mental condition
- Individual or group therapy
- Family therapy as required by law
- Lab and testing
- Take-home drugs you get in a facility

In this benefit, outpatient visit means a clinical treatment session with a mental health provider.

Alcohol and Drug Dependence (Also called "Chemical Dependency" or "Substance Abuse Disorder Treatment")

This plan covers all of the following services:

- Inpatient and residential treatment and outpatient care to manage or reduce the effects of the alcohol or drug dependence
- Individual, family or group therapy
- Lab and testing
- Take-home drugs you get in a facility

To be covered, mental health care, behavioral health care and substance abuse treatment must be provided by:

- A physician (MD or DO) who is a psychiatrist, developmental pediatrician, or pediatric neurologist
- A hospital
- A state hospital maintained by the state of Washington for the care of the mentally ill
- A state-licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A state-licensed masters-level mental health clinician (e.g., licensed clinical social worker, licensed marriage and family counselor, licensed mental health counselor)
- A state-licensed occupational or speech therapist
- A state-licensed psychologist
- Licensed community mental health agency or behavioral health agency

Applied Behavioral Analysis (ABA) Therapy

This plan covers applied behavioral analysis (ABA) therapy. The member must be diagnosed with one of the following disorders:

- 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 Board-Certified Behavior Analyst (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 and if not, who is 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

The Mental Health, Behavioral Health and Substance Abuse benefit does not cover:

- Treatment of sexual dysfunctions such as impotence
- Institutional care, except that services are covered when provided for an illness or injury treated in an acute care hospital, or inpatient/residential treatment provided for a mental health condition
- EEG biofeedback or neurofeedback
- Outward bound, wilderness, camping or tall ship programs or activities
- Mental health tests that are not used to assess a covered mental condition or plan treatment. This plan does not cover tests to decide legal competence or for school or job placement.

Maternity and Newborn Care

This plan covers health care providers and facility charges for prenatal care, delivery and postnatal care for all covered female members. Hospital stays for maternity and newborn care are not limited to less than 48 hours for a vaginal delivery or less than 96 hours following a cesarean section. A length of stay that will be longer than these limits must be prior authorized. See ***Prior Authorization*** for details.

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 under ***Eligibility and Enrollment***.

This benefit covers:

- Prenatal and postnatal care and screenings (including in utero care)
- Home birth services, including associated supplies, provided by a licensed women's health care provider who is working within their license and scope of practice
- Nursery services and supplies for newborn
- Genetic testing of the child's father is covered

This benefit does not cover:

- Outpatient x-ray, lab and imaging. These services are covered under ***Diagnostic Lab, X-ray and Imaging***.
- Home birth services provided by family members or volunteers

Home Health Care

Home health care services must be part of a home health care plan. These services are covered when a qualified provider certifies that the services are provided or coordinated by a state-licensed or Medicare-certified home health agency.

Covered employees of a home health agency 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.

Covered services provided and billed by a home health agency include:

- Home visits and acute nursing (short-term nursing care for illness or injury)
- Home medical equipment, medical supplies and

devices.

- Prescription drugs and insulin provided by and billed by a home health care provider or home health agency
- Therapeutic services such as respiratory therapy and phototherapy

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services provided by family members or volunteers
- Services or providers not in the written plan of care or not named as covered in this benefit
- Custodial care
- Nonmedical services, such as housekeeping
- Services that provide food, such as Meals on Wheels or advice about food

Hospice Care

A hospice care program must be provided in a hospice facility or in your home by a hospice care agency or program.

Covered services include:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a medical social worker who is working under the direction of a physician; this may include counseling for the purpose of helping you and your caregivers to adjust to the approaching death
- Services provided by a qualified provider associated with the hospice program
- Short term inpatient care provided in a hospice inpatient unit or other designated hospice bed in a hospital or skilled nursing facility; this care may be for the purpose of occasional respite for your caregivers, or for pain control and symptom management
- Home medical equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness
- Home health aide services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms
- Palliative care for members facing serious, life-threatening conditions, including expanded access to home based care and care coordination. Participation in palliative care is usually approved for 12 months at a time and may be extended based on the member's specific condition.

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services provided by family members or volunteers
- Services or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Nonmedical services, such as housekeeping, dietary assistance or spiritual bereavement, legal or financial counseling
- Services that provide food, such as Meals on Wheels or advice about food

Rehabilitation and Habilitation Therapy

This plan covers rehabilitation and habilitation therapy. Benefits must be provided by a licensed physical therapist, occupational therapist, speech language pathologist or a licensed qualified provider. Services must be prescribed in writing by your provider. The prescription must include site, type of therapy, how long and how often you should get the treatment.

Rehabilitative therapy is therapy that helps get a part of the body back to normal health or function. It includes therapy to restore or improve a function that was lost because of an accidental injury, illness or surgery.

Habilitation therapy is therapy that helps a person keep, learn or improve skills and functioning for daily living. Examples are therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, aural (hearing) therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings, including school-based settings.

Services provided for treatment of a mental health condition are provided under the ***Mental Health, Behavioral Health and Substance Abuse*** benefit.

Day limits listed in the ***Summary of Your Costs*** do not apply to cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or disease.

Inpatient Care

You can get inpatient care in a specialized rehabilitative unit of a hospital. If you are already an inpatient, this benefit will start when your care becomes mainly rehabilitative.

You must get prior authorization from us before you get inpatient treatment. See ***Prior Authorization*** for details.

This plan covers inpatient rehabilitative therapy only when it meets these conditions:

- You cannot get these services in a less intensive setting
- The care is part of a written plan of treatment prescribed doctor

Outpatient Care

This plan covers outpatient rehabilitative services only when it meets these conditions:

This plan covers the following types of outpatient therapy:

- Physical, speech, hearing and occupational therapies
- Chronic pain care
- Cardiac and pulmonary therapy
- Cochlear implants
- Home medical equipment, medical supplies and devices

This benefit does not cover:

- Recreational, vocational or educational therapy
- Exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that the ill, injured or impaired member does not actively take part in
- Gym or swim therapy
- Custodial care

Skilled Nursing Facility and Care

This plan covers skilled nursing facility services. Covered services include room and board for a semi-private room, plus services, supplies and drugs you get while confined in a skilled nursing facility. Sometimes a patient goes from acute nursing care to skilled nursing care without leaving the hospital. When that happens, this benefit starts on the day that the care becomes primarily skilled nursing care.

Skilled nursing care is covered only during certain stages of recovery. It must be a time when inpatient hospital care is no longer medically necessary, but care in a skilled nursing care facility is medically necessary. Your doctor must actively supervise your care while you are in the skilled nursing facility.

We cover skilled nursing care provided after hospitalization at the long-term care facility (see ***Definitions***) where you were residing immediately prior to your hospitalization when your primary care provider determines that the medical care you need can be provided at that facility, and that facility satisfies our standards, terms and conditions for long-term care facilities, accepts our rates, and has all applicable licenses and certifications.

You must get prior authorization from us before you get treatment. See ***Prior Authorization*** for details.

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

Services must be prescribed by your physician. Medically necessary supplies, devices and HME are covered, subject to the terms and conditions described in this plan. Documentation must be provided which includes; the prescription stating the diagnosis, the reason the service is required and an estimate of the duration of its need. For this benefit, this includes services such as prosthetic and orthotic devices, oxygen and oxygen supplies, diabetic supplies and wheelchairs. Apparatuses used to support, align, correct, or improve the function of moving parts are covered.

Prior Authorization is required for some medical supplies/devices, home medical equipment, prosthetics and orthotics. Please see ***Prior Authorization*** for additional information.

Home Medical Equipment (HME)

This plan covers rental of medical and respiratory equipment (including fitting expenses), 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. Benefits may also be provided for the initial purchase of equipment, in lieu of rental. In cases where an alternative type of equipment is less costly and serves the same medical purpose. We will provide benefits only up to the lesser amount. Repair or replacement of medical or respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical and respiratory equipment includes, but is not limited to, wheelchairs, hospital-type beds, traction equipment, ventilators and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps and insulin infusion devices (including any sales tax).

Medical Supplies

Medical supplies include, but are not limited to dressings, braces, splints, rib belts and crutches, as well as related fitting expenses. Also included are diabetic care supplies such as blood glucose monitor, insulin pump (including accessories), and insulin infusion devices.

Medical Vision Hardware

This plan covers medical vision hardware including eyeglasses, contact lenses and other corneal lenses for members age 19 and older when such devices are required for the following:

- Corneal ulcer
- Bullous keratopathy
- Recurrent erosion of cornea
- Tear film insufficiency
- Aphakia
- Sjogren's disease
- Congenital cataract
- Corneal abrasion
- Keratoconus

Medical vision hardware for members under age 19 is covered for all medically necessary diagnosis. See ***Pediatric Vision Services***.

Prosthetics and Orthotic Devices

Benefits for external prosthetic devices (including fitting expenses) are covered 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 cannot be repaired. Replacement devices must be prescribed by a physician because of a change in your physical condition.

Shoe Inserts and Orthopedic Shoes

Benefits are provided for medically necessary shoes, inserts or orthopedic shoes. Covered services also include training and fitting. Benefits are provided as shown in the ***Summary of Your Costs***.

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs. These services are covered under the ***Prescription Drugs***.
- 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
- Over the counter orthotic braces and/or cranial banding
- Non wearable, defibrillator, trusses and ultrasonic nebulizers
- Blood pressure cuff/monitor (even if prescribed by a physician)
- Enuresis alarm
- Compression stockings which do not require a prescription
- Structural modifications to your home and/or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation of a sport, recreation or similar activity
- Penile prostheses
- Routine eye care services including eye glasses and contact lenses
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under ***Surgery Services***. Items provided and billed by a hospital are covered under the ***Hospital Services*** benefit for inpatient and outpatient care.

OTHER COVERED SERVICES

The services listed in this section are covered as shown on the ***Summary of Your Costs***.

Acupuncture

Benefits are provided for acupuncture services that are medically necessary to relieve pain, to help with anesthesia for surgery, or to treat a covered illness, injury, or condition.

Allergy Testing and Treatment

This plan covers allergy tests and treatments. Covered services include testing, shots given at the doctor's office, serums, needles and syringes.

Chemotherapy and Radiation Therapy

This plan covers the following services:

- Outpatient chemotherapy and radiation therapy services
- Extraction of teeth to prepare the jaw for treatment of neoplastic disease
- Supplies, solutions and drugs (See ***Prescription Drugs*** for oral chemotherapy drugs)

You may need prior authorization from us before you get treatment. See the detailed list at premera.com.

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 ***Office and Clinic Visits***, and lab tests are covered under ***Diagnostic Lab, X-ray and Imaging***.

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 investigative 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.

Dental Injuries

This plan covers injuries to teeth, gums or jaw. Covered services include exams, consultations and dental treatment.

Services are covered when all of the following are true:

- Treatment is needed because of an injury
- The treatment is done within 12 months of the injury. If the treatment cannot be completed within 12 months, you can ask for an extension. We must receive your request for an extension no more than 12 months after the injury.
- The treatment is done on the natural tooth structure. The teeth were free from decay and functionally sound when the injury happened. "Functionally sound" means that the teeth do not have:
  - Extensive restoration, veneers, crowns, or splints
  - Periodontal (gum) disease or any other condition that would make them weak

Please Note: An injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

Emergency care is covered the same as any other emergency service.

Dental Anesthesia

In some cases, this plan covers general anesthesia, professional services and facility charges for dental procedures. These services can be in a hospital or an ambulatory surgical facility. They are covered only when medically necessary for one of these reasons:

- The member is under age 19 years old, or has a disability and it would not be safe and effective to treat them in a dental office
- You have a medical condition (besides the dental condition) that makes it unsafe to do the dental treatment outside a hospital or ambulatory surgical center

This benefit does not cover the dental procedure. See ***Pediatric Care*** for covered dental services.

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.

After Medicare's waiting period, the deductible and coinsurance for dialysis is waived.

See ***How Providers Affect Your Costs*** for information about when out-of-network providers are covered. If the dialysis services are provided by non-contracted provider and you do not enroll in Medicare, then you will owe the difference between the out-of-network provider's billed charges and the payment we will make for the covered services.

See the ***Summary of Your Costs*** for cost shares and ***Allowed Amount*** for more detail.

Foot Care

This plan covers medically necessary foot care. Covered services include treatment for corns, calluses, toenail conditions other than infection and hypertrophy or hyperplasia of the skin of the feet.

Hearing

Hearing exams and hardware are covered as shown in the ***Summary of Your Costs***.

Infusion Therapy

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. 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. This benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses (including bras)
- Physical complications of all stages of mastectomy, including lymphedemas

Medical Foods

This plan covers medically necessary medical foods for supplementation or dietary replacement for the treatment of inborn errors of metabolism. Medical foods are covered at the same cost shares as other medical services. An example is phenylketonuria (PKU). Benefits include medically necessary enteral formula prescribed by a physician or other health care provider for treatment of eosinophilic gastrointestinal associated disorder or other severe malabsborption disorder. Benefits are provided for all delivery methods of formula.

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

This benefit does not cover other oral nutrition or supplements not used to treat inborn errors of metabolism, even if prescribed by a physician. Includes but is not limited to specialized infant formulas and lactose-free foods.

Spinal and Other Manipulative Treatment

Benefits for spinal and other manipulations are provided as shown in the ***Summary of Your Costs***. Services must be medically necessary to treat a covered illness, injury or condition.

Rehabilitation therapy (such as massage or physical therapies) provided in conjunction with manipulative treatment will accrue toward the ***Rehabilitation and Habilitative*** annual maximums, even when provided during the same visit.

Telehealth Virtual Care Services

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

Benefits for telehealth are provided as shown in the ***Summary of Your Costs***. Services must be medically necessary to treat a covered illness, injury or condition.

Coverage for psychiatric conditions is medically appropriate for crisis/emergency evaluations or when the member is temporarily confined to bed for medical reasons only.

Temporomandibular Joint (TMJ) Disorders

Benefits for TMJ are provided as shown in the ***Summary of Your Costs***. Services must be medically necessary to treat a covered illness, injury or condition.

Therapeutic Injections

This plan covers therapeutic injections given at the doctor's office, including serums, needles and syringes. Your provider may administer three teaching doses per drug, per lifetime, of self-injectable specialty drugs in an office or clinic setting. However, all other self-injectable specialty drugs are covered under the ***Specialty Pharmacy Programs***. For more information on how self-injectable specialty drugs are covered, see ***Prescription Drugs***.

Transplants

This plan covers transplant services when they are provided at an approved transplant center. An approved transplant center is a hospital or other provider that has developed expertise in performing organ transplants or bone marrow or stem cell reinfusion.

It must also meet the other approval standards we use. We have agreements with approved transplant centers in Washington, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we will direct you to an approved transplant center that we've contracted with for transplant services.

No waiting or exclusion periods apply for coverage of transplant services. Please call us as soon as you learn you need a transplant.

Covered Transplants

This plan covers only transplant procedures that are not considered experimental or investigative for your condition. Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet coverage criteria. We review the medical reasons for the transplant, how effective the procedure is and possible medical alternatives.

These are the types of transplants and reinfusion procedures that meet our medical policy criteria for coverage:

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

Under this benefit, transplant does not include cornea transplant or skin grafts. It also does not include transplants of blood or blood derivatives (except bone marrow or stem cells). These procedures are covered the same way as other covered surgical procedures. Please see ***Surgery Services*** for more information on blood and blood derivative coverage.

Recipient Costs

Benefits are provided for services from an approved transplant center and related professional services. This benefit also provides coverage for anti-rejection drugs given by the transplant center.

Covered services consist of all phases of treatment:

- Evaluation
- Pre transplant care
- Transplant
- Follow up treatment

Donor Costs

This benefit covers donor or procurement expenses for a covered transplant. Covered services include:

- Selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell
- Transportation of the donor organ, bone marrow or stem cells, including the surgical and harvesting teams
- Donor acquisition costs such as testing and typing expenses
- Storage costs for bone marrow and stem cells for up to 12 months

Transportation and Lodging

This benefit covers costs for transportation and lodging for the member getting the transplant (while not confined), not to exceed three (3) months. The member getting the transplant must live more than 50 miles from the facility, unless treatment protocols require them to remain closer to the transplant center.

Travel Allowances: Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. Mileage reimbursement will be based on the current IRS medical mileage reimbursement. Please refer to the IRS website http://www.irs.gov for current rates.

Lodging Allowances: Expenses incurred by a transplant patient and companion for hotel lodging away from home is reimbursed based on current IRS guidelines.

Companions: Companion travel and lodging expenses are only covered if they must, as a matter of medical necessity or safety, accompany the member.

- Adult Patient – 1 companion is permitted
- Child Patient – 2 parents or guardians are permitted

Non-Covered Expenses

- Alcohol/tobacco
- Car rental
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her covered companion
- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

EMPLOYEE WELLNESS

Employees of the Group who are enrolled as of the renewal / effective date, are eligible to earn an $100 award by completing the following activities within the first 90 days of the plan year:

- **Biometric Screening.** This screening provides information about blood pressure, glucose, cholesterol and body mass. Knowing these numbers helps you understand your health risks

and make changes to improve your health. There are a variety of methods from which to choose to obtain a biometric screening, which include but are not limited to the following: Home Test Kits or physician office screenings (not all screening types provide information about all of those areas). Obtaining a biometric screening is required to earn the $100 award.

- **Health Risk Assessment**. This is a self-assessment tool that includes questions about health habits. You can take this assessment online on our website, premera.com. Or, if you do not have access to a computer, please call Customer Service at the phone number listed on the back cover.

The award is only available to employees of the Group.

In some cases a health coach may contact you and ask if they can help you improve your health.

EXCLUSIONS

This section lists the services that are either limited or not covered by this plan. They are in addition to the services listed as not covered under ***Covered Services***.

Abortion

Voluntary termination of pregnancy

Amounts Over the Allowed Amount

This plan does not cover amounts over the allowed amount as defined in this plan. If you get services from a non-contracted provider, You will have to pay charges over the allowed amount.

Assisted Reproduction

This plan does not cover:

- Assisted reproduction methods, such as artificial insemination or in-vitro fertilization
- Services to make you more fertile or for multiple births
- Undoing of sterilization surgery
- Complications of these services

Diagnosis and treatment of underlying medical conditions that may cause infertility are covered on the same basis as any other medical condition.

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 Used Up

Broken Appointments

Caffeine Dependence

Charges for Records or Reports

Separate charges from providers for supplying records or reports, except those we request for care management.

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, this plan does not cover personal services or items like meals for guests, long-distance phone, radio or TV and personal grooming, and babysitting. Please see the ***Transplants*** for ***Transportation and Lodging Expenses*** exception.
- Normal living needs, such as food, clothes, housekeeping and transport. This does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Help with meals, diets and nutrition. This includes 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

Contraceptive Services

Cosmetic Services

This plan does not cover services and supplies for cosmetic services, including but not limited to:

- Services performed to reshape normal structures of the body in order to improve or alter your appearance and self-esteem and not primarily to restore an impaired function of the body
- Genital surgery for the purpose of changing genital appearance
- Breast mastectomy or augmentation with or without chest reconstruction for the purpose of changing breast appearance

The only exceptions to this exclusion are:

- Repair of a defect that is the direct result of an injury, see ***Surgery Services***
- Repair of a dependent child's congenital anomaly, see ***Surgery Services***
- Reconstructive breast surgery in connection with a mastectomy, except as stated under ***Mastectomy and Breast Reconstruction Services***
- Correction of functional disorders. This does not include removal of excess skin or fat related to weight loss surgery or the use of weight loss drugs. See ***Surgery Services***

Counseling, Education or Training

This plan does not cover counseling or training in the absence of illness. Examples are job help and outreach, social or fitness counseling or training. Also not covered are:

- Exercise or maintenance-level programs
- 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 covered under ***Mental Health, Behavioral Health and Substance Abuse.***

Court-Ordered Services

This plan does not cover services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Custodial Care

This plan does not cover custodial services, except when it is part of covered hospice care. See ***Hospice Care***.

Dental Care

This plan does not cover dental services except as stated in ***Pediatric Dental Services*** (under age 19).

Donor Breast Milk

Drugs and Food Supplements

This plan does not cover the following:

- Over-the-counter drugs, solutions, supplies, vitamins, food, or nutritional supplements, except as required by law
- Herbal, naturopathic, or homeopathic medicines or devices

Environmental Therapy

This plan does not cover therapy to provide a changed or controlled environment.

Experimental and Investigative Services

This plan does not cover any service that is experimental or investigative, see ***Definitions***. This plan also does not cover any complications or effects of such services. This exclusion does not apply to certain services provided as part of a covered clinical trial. See ***Covered Services***.

Family Members or Volunteers

This plan does not cover services that you give to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer, except as described in ***Home Health and Hospice Care***

Government Facilities

This plan does not cover services provided by a state or federal hospital which is not a participating facility, except for emergency care or other covered services as required by law or regulation.

Growth Hormone

This plan does not cover growth hormones for the following:

- To stimulate growth, except when it meets medical standards
- Treatment of idiopathic short stature without growth-hormone deficiency

Hair Loss

This plan does not cover:

- 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

Hospital Admission Limitations

This plan does not cover hospital stays solely for diagnostic studies, physical examinations, checkups, medical evaluations, or observations, unless:

- The services cannot be provided without the use of a hospital
- There is a medical condition that makes hospital care medically necessary

Illegal Acts and Terrorism

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

- A felony (except for a victim of domestic violence)
- An act of terrorism
- An act of riot or revolt

Laser Therapy

Benefits are not provided for low-level laser therapy for any diagnosis, including vitiligo

Military-Related Disabilities

This plan does not cover services to which you are legally entitled for a military service-connected disability and for which facilities are reasonably available.

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.

Not Eligible for Coverage

The plan does not cover services that are:

- Received or ordered when this plan in not in force
- Not charged for or would not be charged for if this plan were not in force
- You are not required to pay for, other than services covered by a pre-paid plan, such as an HMO or services that the law requires the plan to cover
- Connected or directly related to any service that is not covered by this plan
- Received or ordered when you are not covered under this plan
- Given to someone other than an ill or injured member, except as stated in ***Preventive Care***.

No Charge or You Do Not Have to Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

Non-Treatment 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 and juvenile detention facilities. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations. See ***Mental Health, Behavioral Health and Substance Abuse*** for benefit information.

Not Medically Necessary

Services and places of service that are not medically necessary, even if they are court-ordered.

Orthognathic Surgery

This plan does not cover procedures to make the jaw longer or shorter, except orthognathic surgery and supplies for medically necessary treatment of Temporomandibular Joint (TMJ) Disorders, Sleep Apnea or Congenital Anomalies. See the ***Temporomandibular Joint (TMJ) Disorders*** and ***Surgical Services*** benefits for additional coverage information.

Private Duty Nursing

Benefits are not provided for private duty or 24-hour nursing care. See ***Home Health Care*** for home nursing care benefits.

Provider's License or Certification

This plan does not cover services that the provider's license or certification does not allow him or her to perform. It also does not cover a provider that does not have the license or certification that the state requires. The only exception is for applied behavior analysis providers covered under ***Mental Health, Behavioral Health and Substance Abuse.***

Records and Reports

This plan does not cover separate charges from providers for supplying records or reports, except those we request for clinical review.

Serious Adverse Events and Never Events

This plan does not cover serious adverse events or never events. These are serious medical errors that the U.S. government has identified and published. A "serious adverse event" is an injury that is caused by treatment in the hospital and not by a disease. Such events make the hospital stay longer or cause another health problem. A "never event" should never happen in a hospital. A never event is when the wrong surgery is done, or a procedure is done on the wrong person or body part.

You do not have to pay for services of in-network providers for these events and their follow-up care. In-network providers may not bill you or this plan for these services.

Not all medical errors are serious adverse events or never events. These events are very rare. You can ask us for more details. You can also get more details from the U.S. government. You will find them at **www.cms.hhs.gov**.

Sexual Problems

This plan does not cover problems with your sexual function or response. It does not matter what the

cause is. Drugs, implants or any complications or aftereffects are not covered.

Vision Care

This plan does not cover routine vision exams or other services to improve visual sharpness, except as stated in ***Pediatric Vision Services***. The following items are not covered:

- Glasses, frames and contact lenses
- Vision therapy, eye exercise or training
- Surgeries to improve the refractive character of the cornea and any results of such treatment.

Please see ***Rehabilitation and Habilitation Therapy*** for covered medical eye services.

Voluntary Support Groups

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics anonymous

Weight Loss (Surgery or Drugs)

This plan does not cover surgery, drugs or supplements weight loss or weight control. It also does not cover any complications, follow-up services, or effects of those treatments, except services defined as ***Emergency Care***. This is true even if you have an illness or injury that might be helped by weight loss surgery or drugs. This plan does not cover removal of extra skin or fat that came about as a result of weight loss surgery or drugs.

Work-Related Illness or Injury

This plan does not cover any illness or injury for which you get benefits under:

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

OTHER COVERAGE

Please Note: If you participate in a Health Savings Account (HSA) and have other healthcare 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 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.

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 contact 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 ***Effect on Benefits*** later in this section for rules on secondary plan benefits.
- **Allowable expense** is a healthcare expense, including deductibles, coinsurance and copays, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that is not covered by any of your plans is not an allowable expense.

  The allowable expense for the secondary plan is the amount it allows for the service or supply in the absence of other coverage that is primary. This is true regardless of what method the secondary plan uses to set allowable expenses.

  The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.
- **Custodial parent** 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.
- **Gatekeeper requirements** Any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. Examples are restrictions of coverage to providers in a network, prior authorization, or primary care provider referrals.

Primary and Secondary Rules

A plan that does not 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 healthcare expenses or coverage, that plan is primary. This rule applies 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 does not mention responsibility for healthcare expenses, the plan of the parent with financial responsibility is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, then that plan is the primary plan.
  - If a court decree makes both parents responsible for the child's healthcare 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 healthcare 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 is not 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 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. **However, 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.

If this plan is secondary to a plan with gatekeeper requirements (see ***COB Definitions***), and the member has met the primary plan's gatekeeper requirements for a particular service, this plan's gatekeeper requirements will be waived for that service. This rule will not apply if an alternative procedure is agreed upon between both plans and the member.

Certain facts about your other healthcare 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 ***Right of Recovery/Facility of Payment***.

Please Note: When this plan is secondary prior authorization requirements are waived.

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.

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

THIRD PARTY LIABILITY (SUBROGATION)

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. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. Notwithstanding such right, if you recover from a third party and we may share in the recovery, we will pay our share of the legal expenses. Our share is that percentage of the legal expenses 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 ***Notice***). 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 he amount of your recovery that fully compensates your 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.

SENDING US A CLAIM

Many providers will send claims to us directly. When you need to send a claim to us, follow these simple steps:

Step 1

Complete a claim form. Use a separate claim form for each patient and each provider. You can get claim forms by calling Customer Service or you can print them from our website.

Step 2

Attach the bill that lists the services you received. Your claim must show all of the following information:

- Name of the member who received the services
- Name, address, and IRS tax identification number of the provider
- Diagnosis (ICD) code. You must get this from your provider.
- Procedure codes (CPT or HCPCS). You must get these from your provider.
- Date of service and charges for each service

Step 3

If you are also covered by Medicare, attach a copy of the Explanation of Medicare Benefits.

Step 4

Check to make sure that all the information from Steps 1, 2, and 3 is complete. Your claim will be returned if all of this information is not included.

Step 5

Sign the claim form.

Step 6

Mail your claims to the address listed on the back cover.

Prescription Claims

For retail pharmacy purchases, you do not have to

send us a claim form. Just show your Premera ID card to the pharmacist, who will bill us directly. If you do not show Your Premera ID card, you will have to pay the full cost of the prescription. Send your pharmacy receipts attached to a completed Prescription Drug Claim form for reimbursement. Please send the information to the address listed on the drug claim form.

It is very important that you use your Premera ID card at the time you receive services from an in-network pharmacy. Not using your Premera ID card may increase your out-of-pocket costs.

Coordination of Prescription Claims

If this plan is the secondary plan as described under ***Other Coverage***, You must submit your pharmacy receipts attached to a completed claim form for reimbursement. Please send the information to the address listed under Secondary Prescription Claims included on the drug claim form.

Timely Payment of Claim

You should submit all claims within 365 days of the date you received services. No payments will be made by us for claims received more than 365 days after the date of service. Exceptions will be made if we receive documentation of your legal incapacitation or when required by law or regulation. Payment of all claims will be made within the time limits required.

Notice Required for Reimbursement and Payment of Claims

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

Claim Procedure for Groups Subject to the Employee Retirement Income Security Act of 1974 (ERISA)

We will make every effort to review your claims as quickly as possible.

We will send a written notice to you no later than 30 days after we receive your claim to let you know if your plan will cover all or part of the claim. If we cannot complete the review of your claim within this time period, we will notify you of a 15-day extension before the 30-day time limit ends. If we need more information from you or your provider to complete the review of your claim, we will ask for that information in our notice and allow you 45 days to send us the information. Once we receive the information we need, we will review your claim and notify you of our decision within 15 days.

If your claim is denied, in whole or in part, our written notice (see ***Notice***) will include:

- The reasons for the denial and a reference to the plan provisions used to decide your claim
- A description of any additional information needed to reconsider your claim and why the information is needed
- A statement that you have the right to submit a complaint or appeal
- A description of the plan's complaint or appeal processes

If there were clinical reasons for the denial, you will receive a letter from us stating these reasons.

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

If your provider requires a copay when you receive medical services or supplies, it is not considered a claim for benefits. However, you always have the right to request and obtain from us a paper copy of your explanation of benefits in connection with such a medical service by calling 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, premera.com, for information and secure online access to claims information. To file a claim, please see ***Sending Us A Claim*** for more information.

If your claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals.***

COMPLAINTS AND APPEALS

As a Premera member, you have the right to offer your ideas, ask questions, voice complaints and request a formal appeal to reconsider decisions we have made. Our goal is to listen to your concerns and improve our service to you.

If you need an interpreter to help with oral translation, please call us. Customer Service will be able to guide you through the service.

WHEN YOU HAVE IDEAS

We would like to hear from you. If you have an idea, suggestion, or opinion, please let us know. You can contact us at the addresses and telephone numbers found on the back cover.

WHEN YOU HAVE QUESTIONS

Please call us when you have questions about a

benefit or coverage decision, our services, or the quality or availability of a healthcare service, or our service. We can quickly and informally correct errors, clarify benefits, or take steps to improve our service.

We suggest that you call your provider of care when you have questions about the healthcare they provide.

WHEN YOU HAVE A COMPLAINT

You can call or write to us when you have a complaint about a benefit or coverage decision, Customer Service, or the quality or availability of a health care service. We recommend, but don't require, that you take advantage of this process when you have a concern about a benefit or coverage decision. There may be times when Customer Service will ask you to submit your complaint for review through the formal internal appeals process outlined below.

We will review your complaint and notify you of the outcome and the reasons for our decision as soon as possible, but no later than 30 days from the date we received your complaint.

WHEN YOU DO NOT AGREE WITH A PAYMENT OR BENEFIT DECISION

If we declined to provide payment or benefits in whole or in part, and you disagree with that decision, you have the right to request that we review that adverse benefit determination through a formal, internal appeals process.

This plan's appeals process will comply with any new requirements as necessary under state and federal laws and regulations.

What is an adverse benefit determination?

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

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective.

Appeals of Formulary Decisions

You have the right to appeal any decision we have made regarding coverage for drugs not on the plan's formulary. This includes an internal appeal, and an external review as described in this section. Appeals of formulary decisions must be made in writing.

WHEN YOU HAVE AN APPEAL

After you find out about an adverse benefit decision, you can ask for an internal appeal. Your plan has two levels of internal appeals. Your Level I internal appeal will be reviewed by people who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be done by a provider. They will review all of the information about your appeal and will give you a written decision. If you are not satisfied with the decision, you may request a Level II appeal.

Your Level II internal appeal will be reviewed by a panel of people who were not involved in the Level I appeal. If the adverse benefit determination involved medical judgment, a provider will be on the panel. You may take part in the Level II panel meeting in person or by phone. Please contact us for more details about this process.

Once the Level II review is done, we will give you a written decision.

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigative, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

Who may file an internal appeal?

You may file an appeal for yourself. You can also appoint someone to do it for you. This can be your doctor or provider. To appoint a representative, you must sign an authorization form and send it to us. The address and fax number are listed on the back cover. This release gives us your approval for this person to appeal on your behalf and allows our release of information, if any, to them. If you appoint someone else to act for you, that person can do any of the tasks listed below that you would need to do.

Please call us for an Authorization For Release form. You can also get a copy of this form on our website at premera.com.

How do I file an internal appeal?

You may file an appeal by calling Customer Service or by writing to us at the address listed on the back cover of this booklet. We must receive your appeal request as follows:

- For a Level I internal appeal, within 180 calendar days of the date you were notified of the adverse benefit determination.

- For a Level II internal appeal, within 60 calendar days of the date you were notified of the Level I determination. If you are in the hospital or away from home, or for other reasonable cause beyond your control, we will extend this time limit up to 180 calendar days to allow you to get medical records or other documents you want us to look at.

You may send your written appeal request to the address or fax number on the back cover of this booklet.

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on the back cover of this benefit booklet. You can also get a description of the appeals process by visiting our website at premera.com.

We will confirm in writing that we have your request within 72 hours.

What if my situation is clinically urgent?

If your provider believes that your situation is urgent under law, we will expedite your appeal; for example:

- Your doctor thinks a delay may put your life or health in serious jeopardy or would subject you to pain that you cannot tolerate
- The appeal is related to inpatient or emergency care and you are still in the emergency room or in the ambulance

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements. Please call Customer Service if you want to expedite your appeal. The number is listed on the back cover of this booklet.

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

Can I provide more information for my appeal?

You may give us more information to support your appeal either at the time you file an appeal or at a later date. Mail or fax the information to the address and fax number listed on the back cover of this booklet. Please give us this information as soon as you can.

Can I get copies of information relevant to my appeal?

We will also send you any new or additional information we considered, relied upon or generated in connection to your appeal. We will send it as soon as possible and free of charge. You will have the chance to review it and respond to us before we make our decision.

What happens next?

We will review your appeal and give you a written decision within the time limits below:

- For expedited appeals, as soon as possible, but no later than 72 hours after we got your request. We will call, fax or email and then follow up in writing.
- For appeals for benefit decisions made before you received the services, within 14 days of the date we got your request.
- For all other appeals, including experimental and investigative appeals, within 14 days of the date we got your request. If we need more time to review your request, we may extend the review to no more than 30 days, unless we ask for and receive your agreement for more time after the 30 days.

We will send you a notice (see ***Notice***) of our decision and the reasons for it. If we uphold our initial decision, we will tell you about your right to a Level II internal appeal or to an external review at the end of the internal appeals process. You can also go to the next appeal step if we do not comply with the rules above when we handle your appeal.

Appeals about ongoing care

If you appeal a decision to change, reduce or end coverage of ongoing care because the service is no longer medically necessary or appropriate, we will suspend our denial of benefits during the appeal period. Our provision of benefits for services received during the internal appeal period does not, and should not be assumed to, reverse our denial. If our decision is upheld, you must repay us all amounts that we paid for such services. You will also be responsible for any difference between our allowed amount and the provider's billed charge if the provider is non-contracting.

WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigative, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

We will send you an External Review Request form at the end of the internal appeal process to tell you about your rights to an external review. We must receive your written request for an external review

within 180 days of the date you got our Level II appeal response. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to your request.

You can ask us to expedite the external review when your provider believes that your situation is clinically urgent under law. Please call Customer Service at the number listed on the back cover of this booklet to ask us to expedite your external review.

We will tell the IRO that you asked for an external review. The IRO will let you, your authorized representative and/or your attending physician know where more information may be sent directly to the IRO and when the information must be sent. We will forward your medical records and other relevant materials to the IRO. We will also give the IRO any other information they ask for that is reasonably available to us.

When the IRO completes the external review

Once the external review is done, the IRO will let you and us know their decision within the time limits below:

- For expedited external reviews, as soon as possible, but no later than 72 hours after receiving the request. The IRO will notify you and us immediately by phone, e-mail or fax and will follow up with a written decision by mail.

All other reviews, within 15 days after the IRO gets all the information they need or 20 days from the date the IRO gets your request, whichever comes first.

What Happens Next?

Premera is bound by the IRO's decision. If the IRO overturned our decision, we will implement their decision in a timely manner.

If the IRO upheld our decision, there is no further review available under this plan's appeal process. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service at the number listed on the back cover. If you want to make a complaint or need help filing an appeal, you can also contact the Washington Consumer Assistance Program at any time during this process.

If your plan is governed by the Federal Employee Retirement Income Security Act of 1974 (ERISA), you can also contact the Employee Benefits Security Administration of the U.S. Department of Labor.

Washington Consumer Assistance Program

5000 Capitol Blvd.

Tumwater, WA 98501

1-800-562-6900

E-mail: cap@oic.wa.gov

Employee Benefits Security Administration (EBSA)

1-866-444-EBSA (3272)

ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage and who can be covered under this plan. Only members enrolled on this plan can receive its benefits.

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

To be a subscriber under this plan, you must meet all of the requirements listed below. You 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
- Regularly work the minimum hours required by the Group
- Satisfy any probationary period, if one is required by the Group.

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.

Dependents

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 executive officer of the Group, the spouse is eligible to enroll only as a subscriber.
- The domestic partner of the subscriber. All rights and benefits 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.”

Please Note: Domestic partnerships that are **not** documented in a state registry must meet all requirements as stated in the signed “Affidavit of Domestic Partnership.”

- An eligible 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.

ENROLLMENT IN THE PLAN

The subscriber must enroll on forms provided and/or accepted by us. To obtain coverage, a subscriber must enroll within 60 days after becoming eligible. Enrollment after this initial time period can be accomplished as outlined under ***Open Enrollment*** and ***Special Enrollment***.

Dependent enrollment and payment of any necessary additional Premium must occur within 60 days from the date of marriage or date of registered domestic partnership, birth or placement. Enrollment after this initial time period can be accomplished as outlined under ***Open Enrollment*** and ***Special Enrollment***.

Newborn Child Eligibility and Enrollment

Newborn children are covered automatically for the first 3 weeks from birth. To extend the child’s coverage beyond the 3-week period, the subscriber should follow the steps below. If 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 the new 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 by the Group 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, the child can’t enroll until the next open enrollment period. See ***Open Enrollment*** later in this section.

Enrollment after this initial time period can be accomplished as outlined under ***Open Enrollment*** and ***Special Enrollment***.

Adopted Child Eligibility and Enrollment

- 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, the child can’t enroll until the next open enrollment period. See ***Open Enrollment***.

Children Acquired Through Legal Guardianship

A legally placed ward or foster child is added when we receive the completed enrollment application, any required subscription charges, and a copy of the court or other order (signed by a judge or other state agency) within 60 days. Coverage for an eligible legal ward or foster 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, the child can’t enroll until the next open enrollment period. See Open Enrollment.

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. When subscription charges being paid do not already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

SPECIAL ENROLLMENT

The plan allows employees and dependents who didn't enroll when they were first eligible or at the plan's last open enrollment period to enroll outside the plan's annual open enrollment period only in the cases listed below. If we don't receive a completed enrollment application within the time limits stated below. See ***Open 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 coverage purchased through the Exchange, due to an error by the Exchange, the insurer, or Health and Human Services (HHS)
  - Loss of eligibility for Medicaid or a public program providing health benefits
  - A permanent change in residence, work, or living situation, where the prior health plan does not provide coverage in the new service area
  - 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, or plan no longer offers benefits to the class of similarly situated individuals
  - 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 day after 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 Health Plan*** in the case of marriage, birth or adoption. The eligible employee may also choose to enroll without enrolling any 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 ***Eligibility and Enrollment*** 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
- The loss of coverage under a Student Insurance plan (involuntary or voluntary)
- Experience an exceptional circumstance that prevented enrollment in coverage
- Victims of domestic abuse/violence or spousal abandonment and their dependents

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.

When you enroll for coverage under a different group healthcare plan also offered by the Group, 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.

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by the Group. Transfers also occur if the Group replaces another plan 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, 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:

- Out-of-pocket maximum
- Calendar year deductible. Please note that we will credit expenses applied to your prior plan's calendar year deductible **only** when they were incurred in the current calendar year. Expenses incurred during October through December of the prior year are not credited toward this plan's calendar year deductible for the current year.

TERMINATION OF COVERAGE

EVENTS THAT END COVERAGE

Coverage will end without notice (see ***Notice***) on the last day of the month for which subscription charges have been paid 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 ***Dependents*** above.

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 (see ***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. See ***Continuations of Coverage*** 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 (see ***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** (see ***Notice***) **to the Group if:**

- Fraud or other intentional misrepresentation of material fact is made by the Group, as explained in ***Other Information About My Plan***
- 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 nonpayment
- Changes or implementation of federal or state laws that no longer permit the continued offering

of this contract

- We discontinue this contract, as allowed by law. In such instance we will give at least a 90-day notification of the discontinuation.
- We withdraw from a service area or from a segment of a service area, as allowed by law
- We are otherwise permitted to do so by law

CONTINUATION OF COVERAGE

There are specific requirements, time frames and conditions which must be followed in order to be eligible for continuation of coverage and which are generally outlined below. Please contact your employer/group as soon as possible for details if you think you may qualify for continuation of coverage.

Continued Eligibility for a Disabled Child

Coverage may continue beyond the limiting age (see ***Dependent Eligibility***) for a child who cannot 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

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

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.

For Groups with 20 or More Employees

If you become ineligible you may continue coverage to the extent required by the federal Consolidated Omnibus Budget Reconciliation Act of 1986, (COBRA) as amended, and Washington state law. You may be eligible to continue coverage on a self-pay basis for 18 or 36 months through COBRA. COBRA is a federal law which requires most employers with 20 or more employees to offer continuation of coverage. How long you may continue coverage on COBRA will depend upon the circumstances which caused you to lose your coverage on the group plan.

Three-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 is not paid when due or within the grace period
- The contract between the Group and us is terminated

Please Note: The three-month continuation period isn't available for those eligible for COBRA coverage once COBRA coverage is exhausted.

Converting to a Nongroup Plan

You may be entitled to coverage under one of our Individual plans 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 to us within 31 days of the date your coverage ends under this plan 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.

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. In addition, enrollment in an individual plan may limit your ability to later purchase an individual 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.

OTHER PLAN INFORMATION

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

Benefits Not Transferable

No person other than you is entitled to receive the benefits of this contract. Such right to these benefits is not transferable. Fraudulent use of such benefits will result in cancellation of your eligibility under this contract and appropriate legal action.

Conformity with the Law

The Group Contract is issued and delivered in the State of Washington and is governed by the laws of the State of Washington, except to the extent pre-empted by federal law. If any provision of the Group Contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Group Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Entire Contract

The entire contract between the Group and us consists of all of the following:

- The contract face page and "Standard Provisions"
- This benefit booklet(s)
- The Group's signed application
- All attachments, endorsements, and riders included or issued hereafter

No representative of Premera Blue Cross 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.

If there is a language conflict in the contract, the benefit booklet (as amended by any attachments, endorsements or riders) will govern.

Evidence of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you, or on your behalf by your healthcare providers. No benefits will be available if the proof isn't provided or acceptable to us.

The Group and You

The Group is your representative for all purposes under this plan and not the representative of Premera Blue Cross. Any action taken by the Group will be binding on you.

Health Care Providers - Independent Contractors

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this contract are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.

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 ***Right of Recovery*** later in this section.

And, if a member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the member's acceptability for coverage, we may, at our option:

- Deny the member's claim
- Reduce the amount of benefits provided for the member's claim
- Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all)

Finally, statements that are fraudulent, intentionally false or misleading on any group form required by us, that affect the acceptability of the Group or the risks to be assumed by us, may cause the Group Contract for this plan to be voided.

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.

Interpretation of Plan

To the extent this plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the employer's responsibilities and our responsibilities include the following:

- The employer is responsible for furnishing summary plan descriptions, annual reports and summary annual reports to Plan participants and to the government as required by ERISA.
- The employer and not Premera is the "Plan Administrator" as defined in ERISA.
- The employer is responsible for providing all notices regarding continuation.
- The employer gives Premera, as acting for the "Plan Administrator", the discretionary authority to determine eligibility for benefits under the Plan and to interpret the terms of the Plan.

Member Cooperation

You're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours).

Notice

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 are 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.

Notice of Information Use and Disclosure

We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.)
- Coordinating benefits with other healthcare plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the Group contract

This information may also be collected, used or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our Customer Service department and ask a representative to mail a request form to you.

Notice of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which we provide benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
- Personal injury protection (PIP)
- Underinsured motorist coverage
- Uninsured motorist coverage
- Any other insurance under which you are or may

be entitled to recover compensation

- The name of any other group or individual insurance plans that cover you.

Rights of Assignment

Notwithstanding any other provision in this contract, and subject to any limitations of state or federal law, in the event that we merge or consolidate with another corporation or entity, or do business with another entity under another name, or transfer this contract to another corporation or entity, this contract shall remain in full force and effect, and bind the subscriber and the successor corporation or other entity.

We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.

Right of Recovery

We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if this contract is voided as described in ***Intentionally False or Misleading Statements***, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right to and Payment of Benefits

Benefits of this plan are available only to members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan.

At our option only and in accordance with the law, we may pay the benefits of this plan to:

- The subscriber
- A provider
- Another health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies our obligation as to payment of benefits.

Venue

All suits or legal proceedings brought against us by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable
- In the state of Washington or the state where you reside or are employed

All suits or legal or arbitration proceedings brought by us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in King County, the state of Washington.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Please see ***Covered Services***.

Additional Information About Your Coverage

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

You may also ask for the following information:

- Your right to seek and pay for care outside of this plan
- The plan's 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 access specialists
- Obtaining prior authorization when needed
- Accreditation by national managed care organizations
- Use of the health employer data information set (HEDIS) to track performance

If you want to receive this information, please go to

our website at premera.com. If you don't have access to the web, please call Customer Service.

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' in-network providers. The Host blue is responsible for its in-network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (non-contracted providers). 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' in-network providers on the lower of:

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

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

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

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 allowed amount 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 allowed amount 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 allowed amount for the claim.

Non-Contracted Providers.

It could happen that you receive covered services from providers outside our service area that do not have a contract with the Host Blue. In most cases we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. Please see the definition of "allowed amount" in ***Important Plan Information*** in this booklet for details on allowed amounts.

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

BlueCard Worldwide® Program

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 BlueCard Worldwide. BlueCard Worldwide is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although BlueCard Worldwide 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 ***Sending Us A Claim*** for more information. However, if you need hospital inpatient care, the BlueCard Worldwide 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 BlueCard Worldwide 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 outside our service area, go to **premera.com** or call 1-800-810-BLUE (2583). You can also get BlueCard Worldwide information by calling the toll-free phone number.

Additional Information About Your Coverage

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

You may also ask for the following information:

- Your right to seek and pay for care outside of this plan
- The plan's 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 access specialists
- Obtaining prior authorization when needed
- Accreditation by national managed care organizations
- Use of the health employer data information set (HEDIS) to track performance

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

DEFINITIONS

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

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Ambulatory Surgical Facility

A healthcare facility where people get surgery without staying overnight. An ambulatory surgical facility must be licensed or certified by the state it is in. It also must meet all of these criteria:

- It has an organized staff of doctors
- It is a permanent facility that is equipped and run mainly for doing surgical procedures
- It does not provide Inpatient services or rooms

Benefit Booklet

Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.

Calendar Year (Year)

A 12-month period that starts each January 1 at 12:01 a.m. and ends on December 31 at midnight.

Chemical Dependency (Also called "Substance Abuse")

Dependent on or addicted to drugs or alcohol. It is an illness in which a person is dependent on alcohol and/or a controlled substance regulated by state or federal law. It can be a physiological (physical) dependency or a psychological (mental) dependency or both. People with Chemical Dependency usually use drugs or alcohol in a frequent or intense pattern that leads to:

- Losing control over the amount and circumstances of use
- Developing a tolerance of the substance, or having withdrawal symptoms if they reduce or stop the use
- Making their health worse or putting it in serious danger
- Not being able to function well socially or on the job

Chemical Dependency includes drug psychoses and drug dependence syndromes.

Claim

A request for payment from us according to the terms of this plan.

Coinsurance

The amount you pay for covered services after you meet your deductible. Coinsurance is always a percentage of the allowed amount. Coinsurance amounts are listed in the ***Summary of Your Costs***.

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.

Comprehensive Oral Evaluation

Comprehensive oral evaluations include complete dental/medical history and general health assessment, complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; the evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screenings.

Congenital Anomaly

A body part that is clearly different from the normal structure at the time of birth.

Copay

A copay is a set dollar amount you must pay your provider. You pay a copay at the time you get care.

Cosmetic Services

Services that are performed to reshape normal structures of the body in order to improve Your appearance and self-esteem and not primarily to restore an impaired function of the body.

Covered Service

A service, supply or drug that is eligible for benefits under the terms of this Plan.

Custodial Care

Any part of a service, procedure, or supply that is mainly to:

- Maintain your health over time, and not to treat specific illness or injury
- Help you with activities of daily living. Examples are help in walking, bathing, dressing, eating, and preparing special food. This also includes supervising the self-administration of medication when it does not need the constant attention of trained medical providers.

Deductible

The amount of the allowed amounts incurred for covered services for which you are responsible before we provide benefits. Amounts in excess of the allowed amount do not accrue toward the deductible.

Dental Emergency

A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.

Dentally Necessary and Dental Necessity

Those covered services which are determined to meet all of the following requirements:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan
- Appropriate and consistent with authoritative dental or scientific literature
- Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider

Dependent

The subscriber's spouse or domestic partner and any children who are on this plan.

Detoxification

Detoxification is active medical management of substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance ingested, repeated vital sign monitoring, and use of medication to manage intoxication or withdrawal.

Observation without active medical management, or any service that is claimed to be detoxification but does not include active medical management, is not detoxification.

Doctor (Also called "Physician")

A state-licensed:

- Doctor of Medicine and Surgery (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 doctor as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist
- Nurse (R.N.) licensed in Washington State

Effective Date

The date your coverage under this plan begins.

Emergency Medical Condition

A medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

- Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy
- Result in serious impairment to bodily functions
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child

Emergency Care

- Services and supplies including ancillary services given in an emergency department
- Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant woman in active labor, to perform the delivery.

Endorsement

A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.

Experimental/Investigative Services

Services that meet one or more of the following:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided
- It is subject to oversight by an Institutional Review Board
- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies

Reliable evidence means only published reports and articles in authoritative medical and scientific literature.

Facility (Medical Facility)

A hospital, skilled nursing facility, approved treatment facility for chemical dependency, state-approved institution for treatment of mental or psychiatric conditions, or hospice. Not all health care facilities are covered under this contract.

Home Medical Equipment (HME)

Equipment ordered by a provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches.

Home Health Agency

An organization that provides covered home health services to a member.

Hospice

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.

Hospital

A healthcare facility that meets all of these criteria:

- It operates legally as a hospital in the state where it is located
- It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients
- It has a staff of doctors that provides or supervises the care
- It has 24-hour nursing services provided by or supervised by registered nurses

A facility is not considered a hospital if it operates mainly for any of the purposes below:

- As a rest home, nursing home, or convalescent home
- As a residential treatment center or health resort
- To provide hospice care for terminally ill patients
- To care for the elderly
- To treat 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 is independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility or as an overnight bed patient.

Limited Oral Evaluation – Problem Focused

A limited oral evaluation – problem focused is an evaluation limited to a specific oral health problem or complaint and may include evaluation of a specific dental problem or oral health complaint, dental emergency and referral for other treatment.

Long-term Care Facility

A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.023, or assisted living facility licensed under chapter 18.20 RCW.

Medical Emergency

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such as 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.

Medically Necessary and Medical Necessity

Services a physician, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must:

- Agree with generally accepted standards of medical practice
- Be clinically appropriate in type, frequency, extent, site and duration., They must also be considered effective for the patient's illness, injury or disease
- Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member

Any person covered under this plan.

Mental Condition

A condition that is listed in the most recent edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**. This does not include conditions and treatments for chemical dependency.

Off-Label Prescription Drugs

Off-label use of prescription drugs is when a drug is prescribed for a different condition than the one for which it was approved by the FDA.

Orthodontia

The branch of dentistry which specializes in 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

A person who gets healthcare services without an overnight stay in a healthcare facility. This word also describes the services you get while you are an outpatient.

Plan

The benefits, terms, and limitations stated in the contract between us and the Group. This booklet is a part of the contract.

Prescription Drug

Drugs and medications that by law require a prescription. This includes biologicals used in chemotherapy to treat cancer. This includes biological products. According to the Federal Food, Drug and Cosmetic Act, as amended, the label on a prescription drug must have the statement on it: "Caution: Federal law prohibits dispensing without a prescription."

Primary Care Provider (PCP)

A provider who both provides primary care and coordinates care to other medical services

Prior Authorization

Planned services that must be reviewed for medical necessity and approved before you receive them in order to be covered.

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.

Covered categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

The providers are:

- Acupuncturists (L.Ac.) (In Washington also called East Asian Medicine Practitioners (E.A.M.P.))
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dental Hygienists (under the supervision of a D.D.S. or D.M.D.)
- 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 (P.A.) (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists (Ph.D.)
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following healthcare facilities and other providers will also be considered providers for the purposes of this plan when they meet requirements above.

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Board Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed in states that have specific licensure for behavior analysts
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

In states other than Washington, "provider" means healthcare practitioners and facilities that are licensed or certified consistent with the laws and regulations of the state in which they operate.

This plan makes use of provider networks as explained in ***How Providers Affect Your Costs***. The defined terms below are how we show a provider's network status.

For providers of dental care, we use two terms:

- **In-Network Providers** are contracted providers that are in your provider network. You receive the highest benefit level when you use an in-network provider. In-network providers will not bill you for the amount above the allowed amount for a covered service. See the ***Summary of Your Costs***.
- **Out-Of-Network Providers** are providers that are not in your provider network. You receive lower benefit coverage for services provided by out-of-network providers, or the service may not be

covered. An out-of-network dental provider will bill you the amount over the allowed amount for a covered service. See the ***Summary of Your Costs***.

For providers of medical care, we use four terms.

- **In-Network Providers** are contracted providers that are in your provider network. Providers who have contracts with other Blue Cross and/or Blue Shield Licensees outside the service area are also treated as in-network providers. You receive the highest benefit level when you use an in-network provider. In-network providers will not bill you for the amount above the allowed amount for a covered service. See the ***Summary of Your Costs***.
- **Out-Of-Network Providers** are providers that are not in your provider network. You receive lower benefit coverage for services provided by out-of-network providers, or the service may not be covered. If the provider is a contracted provider they will not bill you the amount above the allowed amount for a covered service. If the provider is a non-contracted provider they will bill you the amount over the allowed amount for a covered service. See the ***Summary of Your Costs***.
- **Contracted Providers** are providers that have a contract with us. These providers may or may not be in your provider network. If a service provided by an out-of-network contracted provider is covered, the provider will not bill you the amount above the allowed amount for a covered service. See the ***Summary of Your Costs***.
- **Non-Contracted Providers** are providers that do not have a contract with us or Other Blue Cross Blue Shield Licensees. If a service provided by a non-contracted provider is covered, the provider will bill you the amount above the allowed amount for a covered service. See the ***Summary of Your Costs***.

Reconstructive Surgery

Reconstructive Surgery is surgery:

- That restores features damaged as a result of injury or illness
- To correct a congenital deformity or anomaly.

Service Area

Washington (excluding Clark County).

Services

Services are procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.

Skilled Care

Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility licensed by the state to provide nursing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.

Sound Natural Tooth

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured)
- Has not been extensively restored
- Has not become extensively decayed or involved in periodontal disease
- Is not more susceptible to injury than a whole natural tooth

Spouse

Spouse means:

- An individual who is legally married to the subscriber
- An individual who is a state registered domestic partner of the subscriber or who meets the requirements for domestic partner coverage under this plan.

Subscription Charge

The monthly rates we establish as consideration for the benefits offered under this contract.

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.

Visual Oral Screenings or Assessments

Performed by a licensed dentist or dental hygienist under the supervision of a licensed dentist to determine the need for sealants, fluoride treatment, and/or when triage services are provided in settings other than dental offices or dental clinics.

We, Us and Our

Premera

You and Your

A member enrolled in this plan.

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 Administrator At

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

Customer Service

Mailing Address
Premera Blue Cross
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
for the deaf and hard-of-hearing:
1-800-842-5357

Care Management

Prior Authorization
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

Dental Estimate of Benefits

Premera Blue Cross
Attn: Dental Review
P.O. Box 91059, MS 173
Seattle, WA 98111-9159

Fax 425-918-5956

Teladoc

Log on to 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

BlueCard

1-800-810-BLUE(2583)

Website

Visit our website premera.com for information and secure online access to claims information

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