Sample

Peak Care 2000 Gold

SAMPLE

This is a SAMPLE BOOKLET used solely as a model of our standard benefit booklet format and design. THIS ISN’T A CONTRACT. Possession of this booklet doesn’t entitle you or your employer to any right or benefit named or implied herein.
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: Sample
Effective Date: January 1, 2020
Group Number: SAMPLE
Plan: Premera Blue Cross Peak Care 2000 Gold
Certificate Form Number: 49831WA198 (01-2020)
Discrimination is Against the Law

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

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

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

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Ave SW, Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019,

Getting Help in Other Languages

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

 Hairst: (Amharic):

አማርኛ (አማርኛ):

\begin{align*}
\text{ወጡ} & \text{ወጡ} \text{ወጡ} \text{ወጡ} \text{ወጡ} \text{ወጡ} \text{ወጡ} \\
\text{ DXGI } & \text{ DXGI } \text{ DXGI } \text{ DXGI } \text{ DXGI } \text{ DXGI } \text{ DXGI }
\end{align*}


العربية (العربية):

يحتوي هذا الإشعار معلومات هامة. قد يحتوي هذا الإشعار معلومات مهمة يغوصها عليك أو المغطاة التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك توازن مهنة في هذا الإشعار. وقد تحتاج إلى إجراء في توازن مهنة للحفاظ على محفظة الصحة والمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بمكنك دون تكالفة.

اتصل بـ800-722-1471 (TTY: 800-842-5357).

中文 (中文):

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。本通知可能有關重要日期。您可能需要在截止日期前採取行動，以保留您的健康保險或費用補貼。請撥電話 800-722-1471 (TTY: 800-842-5357)。
Français (French):

Kreyòl ayisyen (Creole):

Deutsche (German):
한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 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 알 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357)로 전화하십시오.

ਪੰਜਾਬੀ (Punjabi):
ਫਿਮ ਟੇਟਿਟ ਦੱਖਣ ਦੇ ਨਾਲ ਸੁਰਖਤ ਲਗਦਾ ਹੈ. ਫਿਮ ਟੇਟਿਟ ਦੱਖਣ Premera Blue Cross ਦੇ ਚਲਾਉਣ ਵਾਲੇ ਬਦਲਣ ਵਾਲੇ ਅਧਿਕਾਰੀਆਂ ਦੇ ਸੰਦੇਸ਼ਾਂ ਨਾਲ ਸੁਰਖਤ ਲਗਦਾ ਹੈ. ਫਿਮ ਟੇਟਿਟ ਦੱਖਣ Premera Blue Cross ਦੇ ਚਲਾਉਣ ਵਾਲੇ ਬਦਲਣ ਵਾਲੇ ਅਧਿਕਾਰੀਆਂ ਦੇ ਸੰਦੇਸ਼ਾਂ ਨਾਲ ਸੁਰਖਤ ਲਗਦਾ ਹੈ. 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اطلاعات مهم میباشد. این اطلاعات ممکن است حاوی اطلاعات مهم درباره فرم تقصیف و یا پوشه بیمه ای شما از Premera Blue Cross باشد. به تاریخ های مهم در این اطلاعات توجه نمایید. ممکن است برای حفظ پوشه بیمه شما یا کمک در برداشتن این زنده در مالیات، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. مشخصاً این را بار دیگر کن اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاریران شماره 800-722-1471) تماس بگیرید.

Polskie (Polish):

Português (Portuguese):
Română (Romanian):
Prezentă notificare conține informații importante.

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем 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 (Samoa):
Atonu ua iai i lenei fa’asilasila ni fa’amatalaga e sili ona tauta e tatau ona e malamalama i ai. O lenei fa’asilasila o se fa’asilea ni fa’amatala atili i ai le tulaga o le polokalame, Premera Blue Cross, ua e tauta ma aua atu i ai. Fa’ameoleme, ia e itilo fa’aulei i aso fa’apitoa olo’o iai i lenei fa’asilasila tauta. Masalo o le’a iai ni feau e tatau ona e faia ao le’ia aulia le aso ua tauta i ai lenei fa’asilasila ina ia e itilo pea ma ma aua fa’asilea mai ai le le polokalame te Malo olo’o e ia’ia. Olo’o ia’ia iate e le aia tauta e aua atu i lenei fa’asilasila te lenei fa’amatala te legagana te malamalama i ai auna ma se toliga tupe. Vili atu i le telefonu 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):

ไทย (Thai):
ประกาศที่เรียนรู้ล่าสุด ประกาศนี้จะเรียบร้อยที่สิ้นสุดก่อนที่จะสิ้นสุดนิติสมัยของคุณและ Premera Blue Cross และอาจมีกำหนดเวลาในประกาศนี้ คุณอาจต้องตั้งสิ้นสุดนิติสมัยในกำหนดระยะเวลาที่ระบุต่อไปหรือประกาศนี้จะมีผลบังคับในรูปแบบที่ระบุในข้อความด้วยคุณมีสิทธิ์ที่จะได้รับข้อมูลและข้อมูลที่เกี่ยวกับการขอรับคำชี้แจงทางโทรศัพท์ 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 в цьому повідомленні. Існує Імовірність того, що Вам треба буде здійснити певні кроки у конкретній ситуації, щоб безпеки Ваше здійснення 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):
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 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.
TABLE OF CONTENTS

SUMMARY OF YOUR COSTS ............................................................................................................ 1

IMPORTANT PLAN INFORMATION .................................................................................................. 7
  Calendar Year Deductible ............................................................................................................. 8
  Copays ........................................................................................................................................ 9
  Coinsurance ................................................................................................................................. 9
  Out-of-Pocket Maximum .............................................................................................................. 9
  Allowed Amount .......................................................................................................................... 9

HOW PROVIDERS AFFECT YOUR COSTS ..................................................................................... 10
  Medical Services ........................................................................................................................ 10
  Pediatric Dental .......................................................................................................................... 11

CARE MANAGEMENT .................................................................................................................... 12
  Prior Authorization .................................................................................................................... 12
  Clinical Review .......................................................................................................................... 14
  Personal Health Support Programs ............................................................................................ 14
  Continuity of Care ....................................................................................................................... 14

COVERED SERVICES ..................................................................................................................... 15
  Common Medical Services ........................................................................................................... 15

WELLNESS-BASED PROGRAMS .................................................................................................... 43

EXCLUSIONS .................................................................................................................................. 44

OTHER COVERAGE ....................................................................................................................... 47
  Coordinating Benefits With Other Plans .................................................................................... 48
  Third Party Liability (Subrogation) ............................................................................................. 50

SENDING US A CLAIM .................................................................................................................... 51

COMPLAINTS AND APPEALS ....................................................................................................... 52

ELIGIBILITY AND ENROLLMENT .................................................................................................. 55
  Enrollment in the Plan ................................................................................................................... 56
  Special Enrollment ....................................................................................................................... 57
  Open Enrollment .......................................................................................................................... 58
  Changes in Coverage ..................................................................................................................... 58
  Plan Transfers ............................................................................................................................... 58

TERMINATION OF COVERAGE ...................................................................................................... 58
  Events that End Coverage ............................................................................................................ 58
  Contract Termination .................................................................................................................... 59

CONTINUATION OF COVERAGE .................................................................................................. 59

OTHER PLAN INFORMATION ........................................................................................................ 60

DEFINITIONS .................................................................................................................................. 66
PREMERA BLUE CROSS PEAK CARE 2000 GOLD

This plan uses Tahoma and Dental Choice networks for medical and dental providers.

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. This plan has a different copay for office visits with Specialists and Non-Specialists. To find out which copay you pay to each type of provider, see Important Plan Information.

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Specialist professional visit copay</td>
<td>$20 copay, deductible waived</td>
</tr>
<tr>
<td>Specialist professional visit copay</td>
<td>$50 copay, deductible waived</td>
</tr>
</tbody>
</table>

- The deductible. The below amount you pay each calendar year before this plan covers healthcare costs. If you and one or more of your dependents are enrolled in this plan, the family deductible will apply. When two or more enrolled family members satisfy their individual deductible, we will consider the family deductible to have been met. Then, this plan will begin paying for your family's covered services. This type of deductible is called "embedded".

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual deductible</td>
<td>$2,000 Not Covered</td>
</tr>
<tr>
<td>Family deductible (embedded)</td>
<td>$4,000 Not Covered</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual out-of-pocket maximum</td>
<td>$7,000 Not applicable</td>
</tr>
<tr>
<td>Family out-of-pocket maximum</td>
<td>$14,000 Not applicable</td>
</tr>
</tbody>
</table>

- 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 Preventive Care, Prescription Drugs, Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies, and the Foot Care benefits.
### COMMON MEDICAL SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture</strong></td>
<td>$20 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Acupuncture treatment limited to 12 visits per calendar year, except for substance use disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For office visits see <em>Office and Clinic Visits.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment</strong></td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For office visits see <em>Office and Clinic Visits.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>Deductible, then 20% coinsurance</td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Blood Products and Services</strong></td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Cellular Immunotherapy and Gene Therapy</strong></td>
<td>Covered as any other service</td>
<td>Not covered</td>
</tr>
<tr>
<td>Designated providers only</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy and Radiation Therapy</strong></td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Professional and facility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Covered as any other service</td>
<td>Covered as any other service</td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• <strong>Dental Anesthesia</strong>, when medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Dental Injury</strong></td>
<td>Covered as any other service</td>
<td>Covered as any other service</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray, Lab and Imaging</strong></td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Preventive care screening and tests</td>
<td>20% coinsurance, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Basic diagnostic x-ray, lab and imaging</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Major diagnostic x-ray, lab and imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dialysis</strong></td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For permanent kidney failure. See <em>Dialysis</em> benefit for details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During Medicare’s waiting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After Medicare’s waiting period</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$200 copay, then in-network deductible, 20% coinsurance</td>
<td>$200 copay, then in-network deductible, 20% coinsurance</td>
</tr>
<tr>
<td>services such as x-rays, lab, and professional services. See those covered services for details. (The copay is waived if you are admitted as an inpatient through the emergency room.) • Professional services</td>
<td>Deductible, then 20% coinsurance</td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Foot Care</strong> Routine care that is medically necessary • Office visits • Other professional services</td>
<td>See <em>Office and Clinic Visits</em> Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hearing Care</strong> • <strong>Hearing Exams</strong> 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. • <strong>Hearing Hardware</strong>, limited to $1,000 every 3-calendar year period.</td>
<td>$50 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Home Based Chronic Care</strong> • 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.</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Home Health Care</strong> • Limited to 130 visits per calendar year</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies</strong> Foot orthotics 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.</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hospice Care</strong> • Home visits (not subject to the Home Health Care visit limit) • Respite care, inpatient or outpatient (limited to 14 days lifetime)</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hospital</strong> • Inpatient Care • Facility • Professional • Outpatient Care</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Service</td>
<td>In-Network Providers</td>
<td>Out-Of-Network Providers</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Facility</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Professional</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mastectomy and Breast Reconstruction</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mastectomy and Breast Reconstruction</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Medical Transportation</td>
<td>Deductible, then 0% coinsurance</td>
<td>In-network deductible, then 0% coinsurance</td>
</tr>
<tr>
<td>For Transplants: $5,000 overall limit, per transplant</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>For Cellular Immunotherapy and Gene Therapy</td>
<td>$7,500 overall benefit limit, per episode of care</td>
<td>Special criteria are required for travel benefits to be provided. Please see the benefit for coverage details.</td>
</tr>
<tr>
<td>Medical Transportation</td>
<td>Deductible, then 0% coinsurance</td>
<td>In-network deductible, then 0% coinsurance</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>$20 copay, deductible waived $20% coinsurance, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inpatient and residential services</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Neurodevelopmental (Habilitation) Therapy</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>See Mental Health Care for therapies provided for mental health conditions such as autism.</td>
<td>$50 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inpatient (limited to 30 days per calendar year)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient (limited to 25 visits per calendar year)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

For specialty care see Office and Clinic Visits.
### Office and Clinic Visits
You may have additional costs for other things such as x-rays, lab, therapeutic injections and hospital facility charges. See those covered services for details. Add-on facility charges may apply.

- Office and clinic visits with a Non-Specialist. See *How Providers Affect Your Costs*.
- Office and clinic visits for women's health. For example, gynecologist.
- All other office and clinic visits with a Specialist (including consultations with a pharmacist)

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>$20 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>$50 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Pediatric Care
Limited to members under age 19

#### Pediatric Dental
- Class I Services
- Class II Services
- Class III Services (including medically necessary orthodontia services, including braces and orthodontic retainer for specific malocclusions. See the *Pediatric Dental* benefit for details.)

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>20% coinsurance, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Deductible, then 50% coinsurance</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

#### Pediatric Vision
- Routine exams limited to once per year
- One pair glasses, frames and lenses limited to once per year. Lens features limited to polycarbonate lenses and scratch resistant coating.
- One pair of contacts or a 12-month supply of contacts per calendar year, instead of glasses (lenses and frames)
- Contact lenses and glasses required for medical reasons
- One comprehensive low vision evaluation and four follow up visits in a five calendar year period
- Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>In-Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### YOUR COSTS OF THE ALLOWED AMOUNT

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can receive up to a 12-month supply for contraceptive drugs. <em>Must use contracted pharmacy.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Female contraceptive drugs, devices and supplies (prescription and over-the-counter)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Male contraceptive drugs, devices and supplies (prescription and over-the-counter)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Formulary preferred generic drugs</td>
<td>$15 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Formulary preferred brand drugs</td>
<td>$40 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Formulary non-preferred drugs</td>
<td>$80 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Oral chemotherapy drugs</td>
<td>20% coinsurance, deductible waived</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Prescription Drugs – Mail-Order Pharmacy**

Up to a 90-day supply. *Must use contracted pharmacy.*

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Preventive drugs required by federal health care reform. See Covered Services for details.</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can receive up to a 12-month supply for contraceptive drugs. <em>Must use contracted pharmacy.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Female contraceptive drugs, devices and supplies (prescription and over-the-counter)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Male contraceptive drugs, devices and supplies (prescription and over-the-counter)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Formulary preferred generic drugs</td>
<td>$45 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Formulary preferred brand drugs</td>
<td>$120 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Formulary non-preferred drugs</td>
<td>$240 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Prescription Drugs – Specialty Pharmacy**

Up to a 30-day supply. *Must use contracted pharmacy.*

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% coinsurance, deductible waived</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Preventive Care**

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Seasonal and travel immunizations (pharmacy mass immunizer, travel clinic and county health department)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>• Health education and training (outpatient)</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Nicotine dependency treatment</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Service</td>
<td>In-Network Providers</td>
<td>Out-of-Network Providers</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Nutritional counseling and therapy</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Contraception Management and Sterilization</td>
<td>No charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Mental Health Care for therapies provided for mental health conditions such as autism.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (limited to 30 days per calendar year)</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient (limited to 25 visits per calendar year)</td>
<td>$50 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility care is limited to 60 days per calendar year</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled nursing care in a long-term care facility is limited to 60 days per calendar year</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Spinal and Other Manipulations</td>
<td>$20 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For office visits see Office and Clinic Visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office or home visits</td>
<td>$20 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Other outpatient professional and facility services</td>
<td>20% coinsurance, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inpatient and residential services</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes anesthesia and blood transfusions)</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>See Hospital and Surgical Center Care – Outpatient benefits for facility charges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Center Care - Outpatient</td>
<td>Deductible, then 20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Telehealth Virtual Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premera-designated virtual care providers</td>
<td>$5 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Other providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtual visits with a Non-Specialist</td>
<td>$20 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Virtual visits with a Specialist</td>
<td>$50 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Temporomandibular Joint Disorders (TMJ) Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits with a Non-Specialist</td>
<td>$20 copay, deductible waived</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### IMPORTANT PLAN INFORMATION

This plan is an Exclusive Provider Organization (EPO). This means that the plan is designed to cover care from in-network providers only. Your plan provides you benefits for covered services from providers you access within the Tahoma and Dental Choice network without referrals. You have services for emergency care throughout the United States and wherever you may travel. Please see **How Providers Affect Your Costs** for more information.

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

**Non-Specialist Office Visits**

This plan uses the Tahoma and Dental Choice network.

You pay a lower office visit cost share by using an in-network provider from one of the following providers listed below. Patient-centered care is an approach to healthcare delivery that focuses on ensuring members receive

---

### YOUR COSTS OF THE ALLOWED AMOUNT

<table>
<thead>
<tr>
<th>IN-NETWORK PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Specialist office and clinic visits</strong></td>
<td>$50 copay, deductible waived</td>
</tr>
<tr>
<td><strong>Inpatient facility care</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Other professional services</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Therapeutic Injections</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td>For office visits see <strong>Office and Clinic Visits</strong></td>
<td>Print(Cell(&quot;WKRCoinsOON&quot;))</td>
</tr>
<tr>
<td><strong>Transgender Services</strong></td>
<td>See <strong>Office and Clinic Visits</strong></td>
</tr>
<tr>
<td><strong>Office and clinic visits</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Other professional services</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient facility care</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>See <strong>Office and Clinic Visits</strong></td>
</tr>
<tr>
<td><strong>Office visits</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient facility care</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><strong>Other professional and facility services, including donor search and harvest expenses</strong></td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td><em>All approved transplant centers covered at in-network benefit level.</em></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$20 copay, deductible waived</td>
</tr>
<tr>
<td><strong>Non-hospital urgent care centers.</strong> 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.**</td>
<td>$200 copay, then in-network deductible, 20% coinsurance</td>
</tr>
<tr>
<td><strong>Urgent care centers attached to or part of a hospital</strong></td>
<td>$200 copay, then in-network deductible, 20% coinsurance</td>
</tr>
</tbody>
</table>
the right care at the right time, the first time. By emphasizing care coordination and giving providers incentives for better health outcomes. This program is designed to ultimately lower healthcare costs.

You pay the Non-Specialist copay when you see one of the following in-network provider types:

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

The provider types listed above will always receive the lowest cost shares. Other provider types will be subject to the higher (specialist) cost shares.

If it is necessary for you to receive care outside the Tahoma and Dental Choice network for non-emergent services, you or your provider can contact our Customer Service for assistance.

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

CALENDARYEARDeductible

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.

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* and non-emergent care, 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**

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

**In-Network Providers**

The allowed amount is the fee that we have negotiated with our Tahoma and Dental Choice network providers.
Out-of-Network Providers
Benefits are limited to emergency services only when you see an out-of-network provider.

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 an Exclusive Provider Organization (EPO). This means that the plan is designed to cover care from in-network providers only. Your plan provides you benefits for covered services from providers within the Tahoma and Dental Choice network without referrals. You have coverage for emergency care throughout the United States and wherever you may travel. Please see Providers Outside the Service Area below for more information.

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

If you need assistance, please call Customer Service for more information about finding a provider in your service area. Services provided by a Non-Specialist during an office visit are subject to standard cost shares. For example, if you go to your Non-Specialist and see that Non-Specialist 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. When you see a Specialist, your office visit copay will be the higher copay amount.

See the Summary of Your Costs and Covered Services for details.
A list of in-network providers is available in our Tahoma and Dental Choice 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. 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 Tahoma and Dental Choice network before you receive services.

The Tahoma and Dental Choice provider network directories are 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 Tahoma and Dental Choice provider network. These providers provide medical services at a negotiated fee. This fee is the allowed amount for in-network providers.

You do not need a referral for emergency services wherever you may travel, however most other services are not covered outside of Washington.

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.

Out-of-Network Providers
Out-of-network providers are providers that are not in the Tahoma and Dental Choice network. Except as stated in Benefits For Out-of-Network Providers, or in a few specific benefits, these providers are not covered.

However, 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.

When a service is covered by an out-of-network provider, 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.** Some providers in Washington that are not in the Tahoma and Dental Choice network do have a contract with us. In cases where this plan does not cover these providers, a contracted provider 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. When a service is covered by an out-of-network provider, these providers will bill you the amount above the allowed amount for a covered service. Amounts in excess of the allowed amount doesn’t count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

**Providers Outside the Service Area**

Benefits when you see providers outside of the service area are limited to a medical emergency only, see Definitions, when you receive services and supplies in Clark County, Washington or outside Washington. Covered services and supplies for medical emergencies can be furnished by any providers that meet the following requirements.

- State-licensed or state-certified
- Performing services within the scope of their license or certification

If, by chance, you get emergency care from a provider that has a provider agreement with us in Alaska or the local Blue Cross and/or Blue Shield Licensee through the BlueCard® Program, your out-of-pocket expenses may be reduced. This is because those providers accept the allowable charge for a covered service as payment in full. When you receive covered emergency care from one of these contracted providers, you’re responsible only for any deductible, copays, or coinsurance required by this plan.

**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 at the in-network benefit level. 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 not listed in our 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 Premera Blue Cross, if you were admitted to that hospital by a Tahoma and Dental Choice provider who doesn’t have admitting privileges at a Tahoma hospital.

- Covered emergency services received from providers located outside the United States.

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

**PEDIATRIC DENTAL**

**In-Network Providers**

Our plan makes a sufficient amount and types of providers available to you, 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 Tahoma and Dental Choice Network providers. You have access to these network providers wherever you are in the United States.
When you receive services from Tahoma and Dental Choice Network providers, your claims will be submitted directly to us and available benefits will be paid directly to the dental care provider. Tahoma and 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 Tahoma and 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 Tahoma and 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

You must get Premera’s approval for some services before the service is performed, or you will not have coverage for the service. This process is called prior authorization.

There are two different types of prior authorization required:

1. **Prior Authorization For Benefit Coverage** You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays. This is so that Premera can confirm that these services are medically necessary and covered by the plan.

2. **Prior Authorization To Cover Out-of-Network Providers** You or your in-network provider must get prior authorization in order for an out-of-network provider to be covered by the plan.

How Prior Authorization Works

We will make a decision on a request for services that require prior authorization in writing within 5 calendar days of receipt of all information necessary to make the decision. The response will let you know whether the services are authorized or not, including the reasons why. If you disagree with the decision, you can ask for an appeal. See Complaints and Appeals.

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

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

1. **Prior Authorization for Benefit Coverage**

   **Medical Services, Supplies or Equipment**

   The plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility. Please contact your in-network provider or Premera Customer Service before you receive a service to find out if your service requires prior authorization.

   - **In-network providers or facilities** are required to request prior authorization for the service.
   - **Out-of-network providers and facilities** will not request prior authorization for the service. You have to ask Premera to prior authorize the service.
If you do not ask for prior authorization, this plan will not cover your services. You will have to pay the total cost of the services. These costs do not count toward your plan deductible or out-of-pocket maximum.

Prescription Drugs
The plan has a specific list of prescription drugs that must have prior authorization before you get them at a pharmacy. The list is on our website at premera.com. Your provider can ask for a prior authorization by faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website.

If your provider does not get prior authorization, when you go to the pharmacy to get your prescription, the pharmacy will tell you that you need it. You or your pharmacy should inform your provider of the need for prior authorization. Your provider can fax us an accurately completed prior authorization form for review.

The plan may cover a small supply of the drug to allow more time for the prior authorization. The cost-shares shown in the Summary of Your Costs will apply. In-Network pharmacies will find out if an emergency fill is covered for your drug. The authorized amount of the emergency fill will be no more than the prescribed amount, up to a seven-day supply or the minimum packaging size available at the time the emergency fill is dispensed. Please see the process for emergency fills on our website at premera.com.

If an emergency fill is not allowed for your drug, you can still buy the drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See How Do I File A Claim? for details.

Exceptions to Prior Authorization for Benefit Coverage
The following services do not require prior authorization for benefit coverage, but they have separate requirements:

• The first six visits provided by an in-network provider for rehabilitation and habilitation therapy, spinal manipulative treatment or acupuncture.

• Emergency care and emergency hospital admissions, including emergency drug or alcohol detox in a hospital.

• Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth.

Emergency and childbirth hospital admissions do not require prior authorization, but you must notify us as soon as reasonably possible.

Generally, out-of-network providers are not covered by your plan except for emergency care. However, you or your in-network provider may ask for a prior authorization to cover the out-of-network provider if the services are medically necessary and only available from an out-of-network provider. You or your in-network provider must ask for prior authorization before you receive the services. You will need to reach out to your in-network provider to have them submit the appropriate forms. You may also initiate the process yourself by calling the toll-free customer support number on the back of your ID card.

Please Note: It is your responsibility to get prior authorization for any services that require it when you see a provider that is out-of-network. If you do not get a prior authorization, the services will not be covered. The provider can bill you directly, and you will have to pay the total cost of the services. These costs do not count toward your plan deductible and out-of-pocket maximum.

The prior authorization request for an out-of-network provider must include the following:

• A statement explaining how the provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from an in-network provider, and

• Medical records needed to support the request.

If the out-of-network services are authorized, the plan will cover the service. However, in addition to the cost shares, you must pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Amounts over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.
Exceptions to Prior Authorization for Out-of-Network Providers

Out-of-network providers can be covered without prior authorization for emergency care and hospital admissions for a medical emergency. This includes hospital admissions for emergency drug or alcohol detox or for childbirth.

If you are admitted to an out-of-network hospital due to an emergency condition, those services are always covered. We will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital. In addition to the plan’s cost shares, you will be required to pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Any amounts you pay over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.

If you choose to stay in the out-of-network hospital after you are medically stable and can safely transfer to an in-network hospital, you may be subject to additional charges which may not be covered by your plan.

CLINICAL REVIEW

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

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

You can find our medical policies at premera.com.

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

If you are in active relationship and treatment, and your doctor or health care provider is no longer in your network, you may be able to continue to see that provider for a period of time. An “active relationship” means that you have had three or more visits with the provider within the past 12 months.

Continuity of care does not apply if your provider:

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

You must continue to be enrolled on this plan to be eligible for any continuity of care benefit.

We will notify you immediately if the provider contract termination will happen within 30 days. Otherwise, we will notify you no later than 10 days after the provider’s contract ends if we 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 ends, we will notify you no later than the 10th day after we become aware of this fact.

You can request continuity of care by contacting Care Management. The contact information is on the back cover of this booklet.

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

- The 90th day after we notified you that your 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 ends, non-emergent care from the provider is no longer covered. If we deny your request for continuity of care, you may request an appeal of the denial. Please see Complaints and Appeals.

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 Exclusions and the specific benefits in this section 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, and 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

Please see the Summary of Your Costs for copays, deductible, coinsurance, benefit limits and to review if out-of-network services are covered.

Acupuncture

This benefit covers acupuncture to:

- Relieve pain
- Provide anesthesia for surgery
- Treat a covered illness, injury, or condition

Allergy Testing and Treatment

This benefit covers:

- Testing
- Allergy shots
Serums

Ambulance
This benefit covers:
• Transport to the nearest facility that can treat your condition
• Medical care you get during the trip
• Transport from one medical facility to another as needed for your condition
• Transport to your home when medically necessary
These services are only covered when:
• Any other type of transport would put your health or safety at risk
• The service is from a licensed ambulance
• It is for the member who needs transport

Air or sea emergency medical transportation is covered when:
• The above requirements for ambulance services are met, and
• Geographic restraints prevent ground emergency transportation to the nearest facility that can treat your condition or ground emergency transportation would put your health or safety at risk

Ambulance services that are not for an emergency must be medically necessary and require a prior authorization. See Prior Authorization for details.

Blood Products and Services
Benefits are provided for blood and blood derivatives.

Cellular Immunotherapy and Gene Therapy
Benefits are provided for medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy. The plan will cover designated providers outside the service area when there are no in-network providers within the service area.

Services must meet Premera’s medical policy. You can access our medical policies by contacting Customer Service or going to premera.com. Services also require prior authorization. See Prior Authorization.

Chemotherapy and Radiation Therapy
This benefit covers:
• Outpatient chemotherapy and radiation therapy
• Supplies, solutions and drugs
• Extractions needed to prepare the jaw for radiation treatments

For drugs you get from a pharmacy, see Prescription Drugs. Some services need prior authorization before you get them. See Prior Authorization for details.

Clinical Trials
A qualified clinical trial (see Definitions) is a scientific study that tests and improves treatments of cancer and other life-threatening conditions.

This benefit covers qualified clinical trial medical services and drugs that are already covered under this plan. The cost of prescription medication is covered, unless the trial is for the investigation of the medication itself or the medication is provided for free by the research sponsors. The clinical trial has to be suitable for your health condition. You also have to be enrolled in the trial at the time of the treatment.

Benefits are based on the type of service you get. For example, if you have benefits for an office visit, it’s covered under Office and Clinic Visits, and if you have a lab test, it’s covered under Diagnostic X-ray, Lab and Imaging.

This benefit does not cover:
• Costs for treatment that are not primarily for the care of the patient (such as lab tests performed just to collect data for the clinical trial)
• The drug, device or services being tested
• Travel costs to and from the clinical trial
• Housing, meals, or other nonclinical expenses
• A service that is not consistent with established standards of care for a certain condition
• Services, supplies or drugs that would not be charged, if there were no coverage
• Services provided to you in a clinical trial that are fully paid for by another source
• Services that are not routine costs normally covered under this plan

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 Care**

**Dental Anesthesia**

Anesthesia and facility care done outside of the dentist’s office for medically necessary dental care

This benefit covers:

- Hospital or other facility care
- General anesthesia provided by an anesthesia professional other than the dentist or the physician performing the dental care

This benefit is covered for any one of the following reasons:

- The member is under age 19 and failed patient management in the dental office
- The member has a disability, medical or mental health condition making it unsafe to have care in a dental office
- The severity and extent of the dental care prevents care in a dental office

**Dental Injury**

Treatment of dental injuries to teeth, gum and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment
- Oral surgery

This benefit is covered on sound and natural teeth that:

- Do not have decay
- Do not have a large number of restorations such as crowns or bridge work
- Do not have gum disease or any condition that would make them weak

Care is covered within 12 months of the injury. If more time is needed, please ask your doctor to contact Customer Service.

This benefit does not cover injuries from biting or chewing, including injuries from a foreign object in food.

**Diagnostic X-ray, Lab and Imaging**

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

Basic services include:

- Bone density screening for osteoporosis
- Cardiac testing
- Pulmonary function testing
- Diagnostic imaging and scans such as x-rays
- Lab services
- Mammograms (including 3-D mammograms) for a medical condition
• Neurological and neuromuscular tests
• Pathology tests
• Echocardiograms
• Standard ultrasounds

Major services include:
• Computed Tomography (CT) scan
• High technology ultrasounds
• Nuclear cardiology
• Magnetic Resonance Imaging (MRI)
• Magnetic Resonance Angiography (MRA)
• Positron Emission Tomography (PET) scan

For additional details see the following benefits:
• Preventive Care
• Hospital
• Emergency Room

Some tests need to be approved before you receive them. See Prior Authorization for details.

Dialysis

This benefit includes dialysis services received in an outpatient setting or in your home.

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. See Allowed Amount in Important Plan Information for more information.

Emergency Room

This benefit covers:
• Emergency room and doctor services
• Equipment, supplies and drugs used in the emergency room
• Services and exams used for stabilizing an emergency medical condition. This includes emergency services arising from complications from a service that was not covered by the plan.
• Diagnostic tests performed with other emergency services
• Emergency detoxification

You need to let us know if you are admitted to the hospital from the emergency room as soon as possible. See Prior Authorization for details.

You may need to pay charges over the allowed amount if you get care from a provider not in your network. See How Providers Affect Your Costs for details.
Foot Care
This benefit covers the following medically necessary foot care services that need care from a doctor:
• Foot care for members with impaired blood flow to the legs and feet when it puts the member at risk
• Treatment of corns, calluses and toenails
This benefit does not cover routine foot care, such as trimming nails or removing corns and calluses, that do not need care from a doctor.

Hearing Care
Hearing Exams
This benefit covers:
• Examination of the inner and exterior of the ear
• Observation and evaluation of hearing, such as whispered voice and tuning fork
• Case history and recommendations
• Hearing testing services, including the use of calibrated equipment
This benefit does not cover:
• Hearing hardware
• Fitting examinations for hearing hardware

Hearing Hardware
To receive your hearing hardware benefit:
• You must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA) before obtaining hearing aids
• You must purchase a hearing aid device
This benefit covers:
• Hearing aids (monaural or binaural) prescribed as a result of an exam
• Ear molds
• The hearing aid instruments
• Hearing aid rental while the primary unit is being repaired
• The initial batteries, cords and other necessary ancillary equipment
• A warranty, when provided by the manufacturer
• A follow-up consultation within 30 days following delivery of the hearing aids with either the prescribing physician or audiologist
• Repairs, servicing, and alteration of hearing aid equipment purchased under this benefit
This benefit does not cover:
• Hearing aids purchased before your effective date of coverage under this plan
• Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids
• Hearing aids that exceed the specifications prescribed for correction of hearing loss
• Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended
• Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

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

You may be charged for items such as x-rays, lab tests, medical equipment and supplies.
For more details see:
- The *Summary of Your Costs*
- *Diagnostic X-Ray, Lab and Imaging*
- *Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies*

**Home Health Care**
Care is covered when a doctor states in writing that care is needed in your home. The care needs to be done by staff who works for a home health agency that is state-licensed or Medicare-certified.

Home health care provided as an alternative to hospitalization must have a written plan of care from your doctor. This type of care is not subject to any visit limit shown in the *Summary of Your Costs*. Medically intensive care in the home or skilled hourly care provided as an alternative to facility-based care need prior authorization by the plan. See *Prior Authorization*.

This benefit covers:
- Home visits and short-term nursing care
- Home medical equipment, supplies and devices
- Prescription drugs given by the home health agency
- Therapy, such as physical, occupational or speech therapy to help regain function

Only the following employees of a home health agency are covered:
- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

This benefit does not cover:
- Over-the-counter drugs, solutions and nutritional supplements
- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature.
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels or advice about food

**Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies**
This benefit covers:

*Home medical equipment (HME)* and fitting expenses. This plan also covers rental of HME, not to exceed the purchase price.

Covered items include:
- Wheelchairs
- Hospital beds
- Traction equipment
- Ventilators
- Diabetic equipment, such as an insulin pump

**Medical Supplies** such as:
- Dressings
- Braces
- Splints
- Rib belts
• Crutches
• Blood glucose monitor and supplies
• Supplies for an insulin pump

**Medical Vision Hardware** for members age 19 and older to correct vision due to medical eye conditions such as:
• Corneal ulcer
• Bullous keratopathy
• Recurrent erosion of cornea
• Tear film insufficiency
• Aphakia
• Sjogren's disease
• Congenital cataract
• Corneal abrasion
• Keratoconus

For medical vision hardware for members under age 19 see **Pediatric Vision** under **Pediatric Care** for benefit details.

**External Prosthetics and Orthotic Devices** used to:
• Replace absent body limb and/or
• Replace broken or failing body organ

**Orthopedic Shoes and Shoe Inserts**
Orthopedic shoes for the treatment of complications from diabetes or other medical disorders that cause foot problems.

You must have a written order for the items. Your doctor must state your condition and estimate the period of its need. Not all equipment or supplies are covered. Some items need prior authorization from us (see **Prior Authorization**).

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
• 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
• Physical changes to your house and/or personal vehicle
• Orthopedic shoes used for sport, recreation or similar activity
• Penile prostheses
• Routine eye care
• Prosthetics, intraocular lenses, equipment or devices which require surgery. These items are covered under **Surgery**

**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

Hospital

This benefit covers:

- Inpatient room and board
- Doctor and nurse services
- Intensive care or special care units
- Operating rooms, procedure rooms and recovery rooms
- Surgical supplies and anesthesia
- Drugs, blood, medical equipment and oxygen for use in the hospital
- X-ray, lab and testing billed by the hospital

Even though you stay at an in-network hospital, you may get care from doctors or other providers who do not have a network contract at all. In that case, you will have to pay any amounts over the allowed amount.

You pay out-of-network cost-shares if you get care from a provider not in your network. See How Providers Affect Your Costs for details.

We must approve all planned inpatient stays before you enter the hospital. See Prior Authorization for details.

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
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

**Infusion Therapy**

Fluids infused into the vein through a needle or catheter as part of your course of treatment.

Infusion examples include:

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

This benefit covers:

- Outpatient facility and professional services
- Professional services provided in an office or home
- Prescription drugs, supplies and solutions used during infusion therapy

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

**Mastectomy and Breast Reconstruction**

Mastectomy and breast reconstruction services are covered on the same basis as any other condition.

Benefits are provided for mastectomy necessary due to disease, illness or injury. This benefit covers:

- Reconstruction of the breast on which mastectomy was performed
- Surgery and reconstruction of the other breast to produce a similar appearance
- Inpatient care
- Physical complications of all stages of mastectomy, including lymphedema treatment and supplies
- Inpatient Care

Planned hospital admissions require prior authorization, see *Prior Authorization* for details.

**Maternity Care**

This benefit covers health care providers and facility charges for prenatal care, delivery and postnatal care for all covered female members. Hospital stays for maternity 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 have prior authorization. See *Prior Authorization* for details.

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
- Abortion

This benefit does not cover:

- Outpatient x-ray, lab and imaging. These services are covered under *Diagnostic X-ray, Lab and Imaging*.
- Depression screening for pregnant and postpartum women are covered as preventive care. See *Preventive Care* for benefit details.

**Medical Foods**

Medical foods are foods that are specially prepared to be consumed or given directly into the stomach by feeding tube under strict supervision of a doctor. They provide most of a person's nutrition. They are designed to treat a specific problem that can be detected using medical tests. Medical foods must be prescribed and supervised by doctors or other health care providers.
This benefit covers:

- Dietary replacement to treat inborn errors of metabolism (example phenylketonuria (PKU))
- Dietary replacement when you have a severe allergy to most foods based on white blood cells in the stomach and intestine that cause inflammation (eosinophilic gastrointestinal associated disorder)
- Other severe conditions when your body cannot take in nutrient from food in the small intestine (malabsorption) disorder
- Disorders where you cannot swallow due to a blockage or a muscular problem and need to be fed through a tube

This benefit does not cover:

- Oral nutrition or supplements not used to treat inborn errors of metabolism or any of the above listed conditions
- Specialized infant formulas
- Lactose-free foods

**Medical Transportation**

This plan provides benefits for travel and lodging only for certain covered services as described below. The member must live more than 50 miles away from the provider performing the services, unless transplant protocols require otherwise. Please contact Customer Service to access our travel partner. **Air transportation and lodging must be booked by Premera’s travel partner in order to be covered.** Prior authorization is also required.

- Travel related to the covered transplants named in the Transplants benefit. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members not in the hospital and for their companions. The member getting the transplant must live more than 50 miles from the transplant facility unless treatment protocols require the member to remain closer to the transplant center.
- Travel for immunotherapy and gene therapy. Benefits are provided for travel for the member and one companion to a designated provider outside the service area, when a designated provider is not available within the service area. Please see Cellular Immunotherapy and Gene Therapy.

See the Summary of Your Costs for any travel benefit limitations.

Benefits are provided for:

- Air transportation expenses between the member’s home and the medical facility where services will be provided. Air travel expenses cover unrestricted coach class, flexible and fully refundable round-trip airfare from a licensed commercial carrier.
- Ferry transportation from the member’s home community
- Lodging expenses at commercial establishments, including hotels and motels, between home and the medical facility where the service will be provided.
- Mileage expenses for the member’s personal automobile
- Ground transportation, car rental, taxicab fares and parking fees, for the member and a companion (when covered) between the hotel and the medical facility where services will be provided.

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The per-day limits and requirements can change if IRS regulations change. Please go to the IRS website, [www.irs.gov](http://www.irs.gov), for details. This summary is not and should not be assumed to be tax advice.

**Companion Travel**

A companion needed for the member’s health and safety is covered. For a child under age 19 a second companion is covered only if medically necessary.

**Reimbursement of Travel Claims**

There are some covered travel services that are not arranged by Premera’s travel partner. For these services, you must submit a Travel Claim Form. A separate claim form is needed for each patient and each commercial carrier or transportation service used. You can get Travel Claim Forms on our website at premera.com. You can also call us for a copy of the form.

You must attach the following documents to the Travel Claim Form:

- A copy of the detailed itinerary as issued by the transportation carrier, travel agency or online travel web site.
The itinerary must identify the names of the passengers, the dates of travel and total cost of travel, and the origination and final destination points.

- Receipts for all covered travel expenses

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

**This benefit does not cover:**

- Charges and fees for booking changes
- Cancellation fees
- First class airline fees
- International travel
- Lodging at any establishment that is not commercial
- Meals
- Personal care items
- Pet care, except for service animals
- Phone service and long-distance calls
- Reimbursement for mileage rewards or frequent flier coupons
- Reimbursement for travel before contacting us and receiving prior authorization
- Travel for medical procedures not listed above
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network or that have not been designated by Premera to perform the services
- Travel insurance

**Mental Health Care**

This benefit covers diagnosis and treatment of mental health conditions. (See Definitions). You must also get these services in the lowest cost type of setting that can give you the care you need. When medically appropriate, services may be provided in your home. This plan will comply with federal mental health parity requirements.

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

This benefit 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
- Institutional care when provided for an illness or injury treated in an acute care hospital or inpatient/residential treatment provided for a mental health condition
- 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. To be covered, mental health care must be provided by:

- A physician (M.D. or D.O.) 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 (Ph.D.)
- Licensed community mental health agency or behavioral health agency
Applied Behavioral Analysis (ABA) Therapy

This benefit covers applied behavioral analysis (ABA) therapy. (See Definitions). 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. BCBA's 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

This benefit does not cover:

- Pharmaceutical Treatment of sexual dysfunctions, such as impotence
- 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.

Neurodevelopmental (Habilitation) Therapy

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

Habilitation therapy is therapy that assists a person to keep, learn or improve skills and functioning for daily living.

Services provided for treatment of a mental health condition are provided under the Mental Health Care, and Substance Use Disorder benefits.

Please see the Summary of Your Costs for visit limits.

Inpatient Care

Inpatient facility services must be furnished and billed by a hospital and will only be covered when services can't be done in a less intensive setting.

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

This benefit covers the following types of outpatient therapy:

- Physical, speech, hearing and occupational therapies
- Home medical equipment, medical supplies and devices

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

This benefit does not cover:

- Social or cultural therapy
- Treatment that the ill, injured or impaired member does not actively take part in

Newborn Care

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

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive maternity care benefits under this plan. To continue benefits beyond the 3-week period please see the dependent eligibility and enrollment guidelines outlined under Eligibility and Enrollment.

This benefit covers:

- Nursery services and supplies for a newborn
- Circumcision

This benefit does not cover:

- Outpatient x-ray, lab and imaging. These services are covered under Diagnostic X-ray, Lab and Imaging.
- Immunizations and outpatient well-baby exams. These services are covered under Preventive Care.

Office and Clinic Visits

This plan covers professional office, clinic and home visits as shown in the Summary of Your Costs. 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 medical equipment, facility fees and office surgeries. Some outpatient services you get from a Specialist must have prior authorization. See Prior Authorization for details. See Urgent Care for urgent or non-emergent care provided in an office or clinic urgent care center. See Preventive Care for coverage of preventive services.

This plan has a different copay for office visits with Specialists and Non-Specialists. To find out which copay you pay to each type of provider, see Important Plan Information.

Pediatric Care

This plan covers pediatric 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 Dental

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 section.

The covered services under this plan are classified as Class I – Diagnostic and Preventive, Class II – Basic, and Class III – Major services. The lists of services that relate to each type are outlined in Covered Services. These services are covered once all requirements below are met. It is important to understand all of these requirements so you can make the most of your dental benefits.

This plan covers pediatric dental services if all of the following requirements are true:

- They must be dentally or medically 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, such as a Registered Nurse (R.N.) or an Advanced Registered Nurse Practitioner (A.R.N.P.), 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. We will request these materials directly from your dental provider. If we're unable to obtain the necessary materials, we'll provide benefits only for those dental services we can verify as a covered service.

Estimate of Benefits (Dental)

You can ask for an Estimate of Benefits before you receive a dental service or services. An Estimate of Benefits verifies your eligibility and the dental benefits of this plan for you and your dental provider. It may also determine what is or is not covered based on your eligibility. This can protect you from unexpected out-of-pocket expenses.

An Estimate of Benefits isn't required 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 you received services. See How to Contact Us for the address and fax number to submit an Estimate of Benefits or call Customer Service if you need help.

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 either of the following, but not both:
  • A complete (full-mouth) series x-ray or 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
  • Occlusal intraoral x-rays are limited to once every 24 months
• 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
• Replacement of space maintainers will be covered only when dentally necessary

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
  • 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 bridges (fixed partial dentures), and complete and partial dentures is limited to once in a 12 month period
  • Re-cement or re-bond of permanent crowns, onlays, inlays, bridges or fixed partial dentures is covered for members age 12 years and older
  • Repair to crowns (indirect), onlays, or inlays is limited to once per tooth per lifetime
  • Pulp vitality tests
• Non-surgical periodontics include:
  • Full mouth debridement is limited to once every 3 years
  • Periodontal maintenance following periodontal therapy is limited to 4 per calendar year for members age 13 and older
• 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
• Inlays, onlays, crowns (indirect) 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. For inlays, onlays, and crowns the service start date is the preparation date. The completion date is the seat date.
• Crown build-ups including pins, cast post and core
• 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 primary posterior and permanent anterior, bicuspid, and molar teeth excluding teeth 1, 16, 17, and 32 teeth only. For root canals and retreatment of root canals, the service start date is the date the canal is opened. The service completion date is the date the canal is filled.
  • 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.
  • 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. For fixed partial bridgework the service start date is the preparation date. The completion date is the seat date.

Initial placement of complete dentures, including overdentures is covered when the denture cannot be made serviceable by a less costly procedure. For dentures the service start date is the impression date. The completion date is the delivery date.

Includes six-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. For resin base partial dentures the service start date is the impression date. The completion date is the delivery date.

Includes six-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 six-month post-delivery care

Dental implant crown and implant abutment related procedures limited to once every 7 years. For implant supported crowns the service start date is the preparation date. The completion date is the seat date. 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
• 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 and for members age 12 and over
• Therapeutic parenteral/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
• Medically necessary orthodontia services including 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)

An Estimate of Benefits is recommended prior to services being received. See Estimate of Benefits.
This benefit does not cover:

- Application of any type of desensitizing medicament
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Cleaning of appliances
- Connector bar or stress breaker
- 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
- Duplicate x-rays
- 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
- Gold foil restorations
- Home use products. Services and supplies that are normally intended for home use such as take-home fluoride, toothbrushes, floss and toothpaste.
- Immediate dentures
- Implants and implant related services including, but not limited to:
  - Surgical placement of implants including indosteal, eposteal, and transosteal;
  - Interim endosseous implants;
  - Endodontic endosseous implants,
  - Sinus augmentations or lift
  - Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis, abutments and reinsertion of prosthesis;
  - Radiographic/surgical implant index;
  - Unspecified implant procedures.
- Increase of vertical dimension. Any service to increase or alter the vertical dimension.
- Indirect pulp caps
- Labial veneers
- Localized delivery of antimicrobial agents
- Medication and supply, such as take-home drugs, pre-medications, therapeutic drug injections and supplies
- 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
- Oral surgery treating fracture of the mandible (jaw)
- Pin retention, in addition to restoration
- 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:
  • Exfoliative cytology sample collection or brush biopsy
  • 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

Pediatric Vision
Coverage for routine eye exams and hardware for members under age 19 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

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

Some prescription drugs require a 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)

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

We will let you and your provider know the decision within 72 hours (24 hours in the case of an expedited review). If the IRO grants your request for an exception, you can review your cost on the Summary of Your Costs for formulary generic and brand name drugs. The IRO's granted exception will be in effect for the duration of the prescription.

**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)
• All FDA approved prescription and over-the-counter oral contraceptive drugs and devices for men and women

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, non-prescription drugs and vitamins, herbal or naturopathic medicines, and nutritional and dietary supplements.
- Non-formulary drugs
- Drugs for cosmetic use such as for wrinkles
- Drugs to promote or stimulate hair growth
- Blood or blood derivatives.
- 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.
- Drugs dispensed for use in a healthcare facility or provider's office or take-home medications.
- Immunizations. See Preventive Care.
- Drugs to enhance fertility or to treat sexual dysfunction of organic origin, including impotence and decrease libido.
- Weight management drugs
- Replacement of lost or stolen medication
- Therapeutic devices or appliances. See Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies.

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 or other vendors. 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 that are covered under this plan and what coverage limitations are in your contract. If
you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service. The phone numbers are shown 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 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
Preventive Care

Preventive care is a 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 benefit covers the following as preventive services:

- Covered preventive services include those 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 (including 3D mammograms). See Diagnostic X-ray, Lab 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.

- Contraceptive management. Includes exams, treatment, prescription and over-the-counter drugs and supplies you get at your provider's office. Prescription and over-the-counter drugs and supplies you get at an in-network pharmacy are also covered, including all FDA approved contraceptives for men and women. FDA approved contraceptives include, but are not limited to emergency contraceptives, and contraceptive devices (insertion and removal). Tubal ligation, and vasectomy are also covered. See Prescription Drugs for prescribed contraceptives.

- 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 or counseling. 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 for children age six and older who are considered obese and for adults with a body mass index of 30 kg/meter squared or higher. The number of therapy visits that are covered as preventive depends on your medical needs. Therapy must cover intensive, multicomponent weight management behavioral interventions without cost share, including group and individual sessions of high intensity and behavioral management activities, such as weight loss goals.

- Preventive drugs required by federal law. See Prescription Drugs.

- Approved nicotine dependency treatment 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 Care and Newborn Care for those covered services.

- Physical exams for basic life or disability insurance

- Work-related disability evaluations or medical disability evaluations

Psychological and Neuropsychological Testing

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

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

Rehabilitation Therapy

This plan covers rehabilitation 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.

Services provided for treatment of a mental health condition are provided under the Mental Health Care, and Substance Use Disorder benefits. Also, see the Neurodevelopmental (Habilitation) Therapy 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 benefit 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 by a doctor

**Outpatient Care**

This benefit covers outpatient rehabilitative services only when it meets these conditions:
- For physical, speech, hearing and occupational therapies

Premera Blue Cross reviews proposed outpatient physical, occupational, and massage therapy for medical necessity before you receive the care. Your first visit to the therapist and the next six visits are not subject to this review. There is no penalty to you if your provider does not ask for the review before providing the care. The review will then be done at the time the claim is submitted.

This benefit covers outpatient rehabilitative services only when it meets these conditions:
- For physical, speech, hearing and occupational therapies
- Cardiac and pulmonary therapy
- Cochlear implants
- Home medical equipment, medical supplies and devices

This benefit does not cover:
- Treatment that the ill, injured or impaired member does not actively take part in
- Therapy for flat feet except to help you recover from surgery to correct flat feet

**Skilled Nursing Facility Care**

This benefit includes:
- Room and board
- Skilled nursing services
- Supplies and drugs
- Skilled nursing care during some stages of recovery
- Skilled rehabilitation provided by physical, occupational or speech therapists while in a skilled nursing facility
- Short or long term stay immediately following a hospitalization
- Active supervision by your doctor while in the skilled nursing facility

We must approve all planned skilled nursing facility stays before you enter a skilled nursing facility. See **Prior Authorization** for details.

This benefit does not cover:
- Acute nursing care
- Skilled nursing facility stay not immediately following hospitalization or inpatient stay
- Skilled nursing care outside of a hospital or skilled nursing facility
- Care or stay provided at a facility that is not qualified per our standards

**Spinal and Other Manipulations**

This benefit covers manipulations to treat a covered illness, injury or condition.

Rehabilitation therapy such as massage or physical therapy provided with manipulations is covered under the **Rehabilitation Therapy** and **Neurodevelopmental (Habilitation) Therapy** benefits.

**Substance Use Disorder**

This benefit covers diagnosis and treatment for substance use disorder. (See Definitions). You must also get these services in the lowest cost type of setting that can give you the care you need. When medically appropriate, services may be provided in your home. This plan will comply with federal mental health parity requirements.

Some services require prior authorization. See **Prior Authorization** for details.
This benefit 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
- Detoxification is covered in any medically necessary location. Emergency detoxification is only covered in a hospital.
- Individual, family or group therapy
- Lab and testing
- Take-home drugs you get in a facility

To be covered, 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 psychologist
- A state-approved substance abuse treatment program
- Licensed community mental health agency or behavioral health agency

Substance Use Disorder benefit does not cover:

- Outward bound, wilderness, camping or tall ship programs or activities
- Testing that is not used to assess a covered substance use disorder or plan treatment.
- Drug or alcohol testing done for school or employment

Surgery

This benefit covers inpatient and outpatient surgical services at a hospital or ambulatory surgical facility, surgical suite or provider’s office. Some outpatient surgeries must have prior authorization 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.
- Surgery to correct underlying medical cause of infertility. Please Note: Benefits are not provided for assisted reproduction techniques, or sterilization reversal.
- Surgical supplies
- Reconstruction surgery that is needed because of an injury, infection or other illness
- The repair of a dependent child’s congenital anomaly
- Cosmetic surgery for correction of functional disorders
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes
- Vasectomy or tubal ligation

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.
- Removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss

**Surgical Center Care – Outpatient**

Benefits are provided for services and supplies furnished by an outpatient surgical center or ambulatory surgical facility.

**Telehealth Virtual Care**

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. Your provider may provide these services, or you may use our Premera-designated virtual care provider.

**Temporomandibular Joint Disorders (TMJ) Care**

TMJ disorders are covered on the same basis as any other condition.

TMJ disorders include those conditions that have some of the following symptoms:

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

This benefit covers:

- Exams
- Consultations
- Treatment

Some services may be covered under other benefits sections of this plan with different or additional cost share, such as:

- X-rays (see Diagnostic X-ray, Lab and Imaging)
- Surgery (see Surgery)
- Hospital (see Hospital)

Some surgeries need authorized before you get them. See Prior Authorization for details.

**Therapeutic Injections**

This benefit covers:

- Shots given in the doctor’s office
- Supplies used during visit, such as serums, needles and syringes
- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

- Immunizations (see Preventive Care)
- Self-injectable drugs (see Prescription Drugs)
- Infusion therapy (see Infusion Therapy)
- Allergy shots (see Allergy Testing and Treatment)

**Transgender Services**

Benefits for medically necessary transgender services are subject to the same cost-shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages. To find the amounts you are responsible for, please see the Summary of Your Costs outlined earlier in this booklet.
Benefits are provided for all transgender surgical services which meet the Premera medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from Customer Service, or at premera.com.

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of transgender surgery, are covered under the surgical benefits applicable to those conditions.

Please Note: Coverage of prescription drugs, and mental health treatment associated with gender reassignment surgery, are eligible under the general plan provisions for prescription drugs and behavioral health, subject to the applicable plan limitations and exclusions.

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 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
- The plan also covers transportation to the transplant facility if you live more than 50 miles away. Please see *Medical Transportation* for benefits.

**Non-Covered Expenses**

- Alcohol/tobacco
- 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

**Urgent Care**

This benefit covers:

Exams and treatment of:

- Minor sprains
- Cuts
- Ear, nose and throat infections
- Fever

Some services done during the urgent care visit may be covered under other benefits of this plan with different or additional cost shares, such as:

- X-rays and lab work
- Shots or therapeutic injections
- Office surgeries

Urgent care centers can be part of a hospital or not. Please see the *Summary of Your Costs* for information about each type of center you may visit.

**WELLNESS-BASED PROGRAMS**

**Employee Assistance Program:** Members have access to a separate Employee Assistance Program through ComPsych that provides a 24-hour toll-free line to speak immediately with masters level intake counselors who can refer the member to a local state-licensed mental health clinician. Members will also have access to online resources for legal, financial and family issues, as well as common stressors of daily life. For more information on the services provided through the program, call ComPsych directly at 1-844-862-0898.

**Interactive Digital Self-Care Platform:** Members will also have access to interactive Computerized Cognitive Behavioral Therapy (CCBT) through ComPsych. These CCBT resources include guided programs on anxiety, chronic pain, depression, mindfulness, substance abuse and much more. The CCBT resources can be accessed at https://www.guidanceresources.com/groWeb/login/login.xhtml.

These programs are offered separately by Premera partners and are not considered to be benefits under this plan. We periodically review the participation and effectiveness of our wellness-based programs, and may alter the programs from time to time. We or our health partner will notify you in advance of any changes to our programs.
EXCLUSIONS

This section lists the services that are either limited or not covered by this plan. In addition to services listed as not covered under Covered Services, the following are excluded from coverage under this plan.

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 any amounts for your services that are over the allowed amount.

Assisted Reproduction

This plan does not cover any assisted reproduction technologies including, but not limited to:

- Artificial insemination or in-vitro fertilization
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

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 other insurance or coverage, such as:

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal Injury Protection (PIP), Medical Payment coverage or Medical Premises coverage
- Any type of liability insurance, such as home owners’ coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits That Have Been Exhausted

Services in excess of benefit limitations or maximums of this plan.

Broken or Missed Appointments

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.
- Normal living needs, such as food, clothes, housekeeping and transport or not prescribed in a home health treatment plan.
- Meals or dietary assistance, including Meals on Wheels.

Complications

This plan does not cover any complications of a non-covered service, including follow-up services or effects of those services. See Emergency Room for emergency benefits.

Cosmetic Services

This plan does not cover drugs, services or supplies for cosmetic services. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

Counseling, Education or Training

This plan does not cover counseling or training in the absence of illness. This includes, but is not limited to job...
help and outreach, social or fitness counseling

- Job help and outreach, social or fitness counseling. Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's Individual Education Program or are otherwise should be provided by school staff.

- Private school or boarding tuition

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

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 non-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 who is not providing services described in Home Health Care or Hospice Care program

Government Facilities

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

Hair Analysis

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 you get while committing a felony, act of terrorism or an act of riot or revolt.

Laser Therapy

Benefits are not provided for low-level laser therapy.
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.

Non-Covered Services
The plan does not cover services or supplies:
• Ordered when this plan is not in effect or when the person is not covered under this plan
• Provided to someone other than an ill or injured member, other than outpatient health education services covered under the Preventive Care benefit. This includes health care provider training or educational services or supplies.
• Directly related to any condition, or related to any other service or supply that is not covered
• You are not required to pay or would not have been charged for if this plan were not in force
• That are not listed as covered under this plan

Non-Treatment Charges
• 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. Housework or chores for the member or helping the member do housework or chores.

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 treatment for covered services. Examples are prisons, nursing homes and juvenile detention facilities. Benefits are provided for medically necessary treatment received in these locations. See Covered Services for specific benefit information.

Not Medically Necessary
Services and places of service that are not medically necessary

Orthognathic Surgery
Procedures to lengthen or shorten the jaw (orthognathic surgery) regardless of the origin of the condition that makes the procedure necessary. The only exception is for repair of a dependent child’s congenital anomaly. See Surgery for specific benefits information.

Provider's Licensing 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 Care and Substance Use Disorder. See Definitions for provider details.

Recreational, Camp and Activity Programs
This plan does not cover recreational, camp and activity-based programs. These programs are not medically necessary and include:
• Gym, swim and other sports programs, camps and training
• Creative art, play and sensory movement and dance therapy
• Recreational programs and camps
• Boot camp programs
• Equine programs and other animal-assisted programs and camps
• Exercise and maintenance-level programs

Serious Adverse Events and Never Events
Members and this plan are not responsible for payment of services provided by in-network providers for serious
Serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-Network providers may not bill members for these services and members are held harmless.

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

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

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) Web page at [www.cms.hhs.gov](http://www.cms.hhs.gov).

**Services or Supplies for which You Do Not Legally 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.

**Sexual Dysfunction**

Diagnosis and treatment of sexual dysfunction, regardless of origin or cause, surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications or penial or other implants.

**Vision Exams**

This plan does not cover routine adult vision exams to test visual acuity and/or to prescribe any type of vision hardware for members age 19 and older.

**Vision Hardware**

This plan does not cover vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses and related supplies except as covered under the [Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies](#) benefit. This plan never covers non-prescription eyeglasses or contact lenses or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

**Vision Therapy**

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

**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. This is true even if you have an illness or injury that might be helped by 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" later in this section for details on primary and secondary plans.

If you do not know which plan your primary plan is, 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 can 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 are any requirements 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.

TRICARE If you are a member of the U.S. military (active or retired) or you have dependents enrolled in the TRICARE program, this plan is the primary plan and TRICARE would be secondary, when required by federal law.

Continuation Coverage If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that is not through COBRA or other continuation law.

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.

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

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 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 the amount of your recovery that fully compensates your for your loss.

UNINSURED AND UNDERINSURED MOTORIST/PERSOAL 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 process claims in the order in which we receive them.

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 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 all you have to pay is a copay for a covered service or supply, it is not a claim for benefits. You can call Customer Service to get a paper copy of an Explanation of Benefits for the service or supply. 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

We know healthcare doesn't always work perfectly. Our goal is to listen, take care of you, and make it simple. If it doesn't go the way you expect, you have two options:
- Complaint – is when you are not satisfied with customer service or the quality of, or access to, medical care.
You can call Customer Service if you have a complaint. We may ask you to send the details in writing. We will send a written response within 30 days.

- **Appeal** – Is a request to review a specific decision we have made

**WHAT YOU CAN APPEAL**

<table>
<thead>
<tr>
<th>Claims and Prior Authorization</th>
<th>Payment</th>
<th>Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denied</td>
<td>Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.</td>
<td></td>
</tr>
</tbody>
</table>

| Enrollment canceled or not issued | No Coverage | You are not eligible to enroll or stay in the plan |

These are examples of adverse benefit determinations. Please see Definitions for more information.

The rest of this section will explain the appeal process. If you still have questions, please call Customer Service. Contact information is on the back of your Premera ID card.

**APPEAL LEVELS**

You have the right to three levels of appeals.

<table>
<thead>
<tr>
<th>Appeal Level</th>
<th>What it means</th>
<th>Deadline to appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>This is your first appeal. Premera will review your appeal.</td>
<td>180 days from the date you were notified of our decision.</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.</td>
<td>60 days from the date you were notified of our Level 1 decision.</td>
</tr>
<tr>
<td><strong>External</strong></td>
<td>If we deny your Level 2 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.</td>
<td>180 days from the date you were notified of our Level 2 decision. OR 180 days from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.</td>
</tr>
</tbody>
</table>

**HOW TO SUBMIT AN APPEAL**

Here are your options for submitting an appeal:

- Submit an appeal form – go to premera.com to access our appeal form. You have the option of attaching additional documentation and a written statement.
- Call Customer Service to submit your appeal. See your Premera ID card for the phone number.
- Write to us at the address listed on the back of this contract.

Submit supporting documentation. This may include chart notes, medical records or a letter from your doctor. Within 72 hours, we will confirm in writing that we have received your request.

If you need help filling out an appeal, or would like a copy of the appeals process, please call Customer Service.

If you would like to review the information used for your appeal, please call Customer Service. The information will be sent as soon as possible and free of charge.
Choose Someone To Appeal For You

Choose someone, including your doctor, to appeal on your behalf. To choose someone else, complete a Member Appeal Form with Authorization located on premera.com. We can’t release your information without this form. You do not need an authorization if your provider is contracted with Premera.

Appeal Response Time Limits

We’ll review your appeal and send a decision within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, a group of people who have not reviewed the case before will review and make a decision.

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>When to expect a response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent appeals</td>
<td>No later than 72 hours. We will call, fax, or e-mail you with the decision, and follow up in writing.</td>
</tr>
<tr>
<td>Pre-service appeals (a decision made by us before you received services)</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Appeals of experimental and investigative denials</td>
<td>Within 20 days</td>
</tr>
<tr>
<td>All other appeals</td>
<td>14-30 days</td>
</tr>
<tr>
<td>External appeals</td>
<td>• Urgent appeals within 72 hours</td>
</tr>
<tr>
<td></td>
<td>• Other IRO appeals within 15 days after the IRO gets the information or 20 days from the date the IRO gets your request</td>
</tr>
</tbody>
</table>

WHAT HAPPENS IF YOU HAVE ONGOING CARE

Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, inpatient care and rehabilitation.

If you appeal a decision that affects ongoing care because we’ve determined the care is no longer medically necessary, we will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved. If our decision is upheld, you must repay all amounts we paid for ongoing care during the appeal review.

WHAT HAPPENS IF IT’S URGENT

If your condition is urgent, you will get our response sooner. Please see the table above. Urgent appeals are only available for services you are currently receiving or have not yet received.

Examples of urgent situations are:

- Your life or health is in serious danger or a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professional or your treating physician
- You are requesting coverage for inpatient or emergency care that you are currently receiving

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

HOW TO ASK FOR AN EXTERNAL REVIEW

- We will tell you about your right to an external review with the written decision of your internal appeal. Go to premera.com to access our external appeal form. You may also write to us directly to ask for an external appeal.
- You must include the signed external appeal form. You may also include medical records and other information.

We will forward your medical records and other information to the Independent Review Organization (IRO). If you have additional information on your appeal, you may send it to the IRO.
ONCE THE IRO DECIDES
For urgent appeals, the IRO will inform you and Premera immediately.

Premera will accept the IRO decision.

If the IRO:

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

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

Washington Consumer Assistance Program
5000 Capitol Blvd
Tumwater, WA 98501

1-800-562-6900
E-mail: cap@oic.wa.gov

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.

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 subscription charges 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**

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.

**Adoptive Children**

- 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.

**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.
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 Continuation 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 Non-group 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.
Benefit Modifications
From time to time, we may change the terms of this contract. You will receive prior written notice of any changes, and 30 days prior written notice of changes to subscription charges (see Notice).

If the terms of this contract change, those changes will not affect benefits to a member during confinement in a facility. Benefit changes will take effect when you leave the facility, or from any other facility you are transferred to, as long as you are still covered under this plan.

No producer or agent of Premera or any other person, is authorized to make any changes, additions, or deletions to this contract or to waive any provision of this contract. Changes, alterations, additions, or exclusions can only be done with the signature of an officer of Premera.

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 with 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.

Independent Corporation
The subscriber hereby expressly acknowledges the understanding that this contract constitutes a contract solely between the subscriber and Premera.

The subscriber further acknowledges and agrees that he or she has not entered into this contract based upon representations by any person other than us, and that no person, entity, or organization other than us shall be
held accountable or liable to the subscriber for any of our obligations to the subscriber created under this contract. This provision shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this contract.

**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.

**Limitations of Liability**

We are not legally responsible for any of the following:

- Epidemics, disasters, or other situations that prevent members from getting the care they need
- The quality of services or supplies that members get from providers, or the amounts charged by providers
- Providing any type of hospital, medical, dental, vision, or similar care
- Harm that comes to a member while in a provider's care
- Amounts in excess of the actual cost of services and supplies
- Amounts in excess of this plan's maximums. This includes recovery under any claim of breach.
- General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages

**Member Cooperation**

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

**Newborn's and Mother's Health Protection Act**

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

**Notice**

We may be required to send you certain notices. We will consider such a notice to be delivered if we mail it to your most recent address in our records. The date of the postmark is the delivery date.

If you are required to send notice to us, the postmark date will be the delivery date. If not postmarked, the delivery date will be the date we receive it.

**Notice of Information Use and Disclosure**

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

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

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

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

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

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

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

**Notice of Other Coverage**

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

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

**Rights of Assignment**

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

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

**Right of Recovery**

We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of 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.

**Workers’ Compensation Insurance**

This contract is not in lieu of, and does not affect, any requirement for coverage by Workers’ Compensation Insurance.

**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 a prior authorization when needed
- Accreditation by national managed care organizations
- Use of the health employer data information set (HEDIS) to track performance

If you want to receive this information, please go to our website at premera.com. 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.

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

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

**BlueCard Program**

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

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

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

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

**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* of this booklet for details on allowed amounts.

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

**Blue Cross Blue Shield Global® Core**

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the “BlueCard service area”), you may be able to take advantage of Blue Cross Blue Shield Global® Core. Blue Cross Blue Shield Global® Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global® Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See *Sending Us A Claim* for more information.

However, if you need hospital inpatient care, the service Center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at 1-800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.
More Questions

If you have questions or need to find out more about the BlueCard Program or Blue Cross Blue Shield Global® Core, please call our Customer Service Department. You can find a provider on premera.com or by calling 1-800-810-BLUE (2583).

Additional Information About Your Coverage

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

You may also ask for the following information:

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

If you want to receive this information, please go to our website at premera.com. 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.

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

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
Applied Behavioral Analysis (ABA)
The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

Autism Spectrum Disorders
Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, as amended or reissued from time to time.

Benefit
What this plan provides for a covered service. The benefits you get are subject to this plan's cost-shares.

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

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

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

Clinical Trials
An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:
- An institutional review board that complies with federal standards for protecting human research subjects; and
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
  - The United States Department of Defense
  - The United States Department of Veterans’ Affairs
  - A nongovernmental research entity abiding by current National Institutes of Health guidelines

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.

Cost-Share
The part of healthcare costs that you have to pay. Examples are deductibles, coinsurance, copayments, and similar charges. It does not include subscription charges, amounts over the allowed amount billed by health care providers who are out of the network, or the cost of services not covered by this plan. See Summary of Your Costs to find out what your cost-shares are.

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 of 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 Health Agency

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

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
Prior authorization is a process that requires you or a provider to follow to determine if a service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care or effectiveness. You must ask for prior authorization before the service is delivered. See Prior Authorization for details.

Provider
A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care-related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of 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.)
- 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, or the service may not be covered. 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, or the service may not be covered. 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

**Rehabilitative Services**

Rehabilitative services or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition.

Rehabilitative services include physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope of his or her license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.
Service Area
Pierce, Thurston and Spokane County, Washington

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

Specialist
A doctor who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse
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.

Subscriber
The person in whose name the plan is issued.

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

Substance Use Disorder (Also called Chemical Dependency)
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 substance use disorders 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
- Substance use disorders, including drug psychoses and drug dependence syndromes.

State and federal law require that the copays and coinsurance for medically necessary outpatient and inpatient services provide to treat substance use disorder will be no more than the copays and coinsurance for medical and surgical services. Prescription drugs to treat substance use disorder are covered under the same terms and conditions as other prescription drugs covered under this plan.
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.

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

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
Contact the Pharmacy Benefit Administrator At
Express Scripts
P.O. Box 747000
Cincinnati, OH  45274-7000
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

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

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

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association