Premera Blue Cross Cascade Silver

$2,500 deductible (individual),
$5,000 deductible (family)

Benefit Booklet for Individual and Families Residing in Washington

49831WA194C (01-2023)

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-607-0546 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-607-0546（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-607-0546 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-607-0546 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-607-0546 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-607-0546 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-607-0546 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-607-0546 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-607-0546（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-607-0546 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-607-0546 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-607-0546 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-607-0546 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-607-0546 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-607-0546 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-607-0546 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-607-0546 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-607-0546 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-607-0546 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-607-0546 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 800-607-0546 تماس بگیرید.

For Individuals and Families Residing in Washington

PLEASE READ THIS CONTRACT CAREFULLY This is a contract between the subscriber and Premera Blue Cross and shall be construed in accordance with the laws of the state of Washington. Please read this contract carefully to understand all of your rights and duties and those of Premera Blue Cross.

GUARANTEED RENEWABILITY OF COVERAGE Coverage under this contract will not be terminated due to a change in your health. Renewability and termination of coverage are described under ***ELIGIBILITY and ENROLLMENT***.

In consideration of timely payment of the full subscription charge, Premera Blue Cross agrees to provide the benefits of this contract subject to the terms and conditions appearing on this and the following pages, including any endorsements, amendments, and addenda to this contract which are signed and issued by Premera Blue Cross.

Premera Blue Cross has issued this contract at Mountlake Terrace, Washington.

Kristin Meadows
General Manager & Vice President Individual Market
Premera Blue Cross

YOUR RIGHT TO RETURN THIS CONTRACT WITHIN TEN DAYS

If you are not satisfied with this contract after you read it, for any reason, you may return it. You have 10 days after the delivery date for a full refund. Delivery date means 5 days after the postmark date. We will refund your payment no more than 30 days after we receive the returned contract. If your refund takes longer than 30 days, we will add 10% to the refund amount.

If you return this contract within the 10-day period, we will treat it as if it was never in effect. However, we have the right to recover any benefits we paid before you returned the contract. We may deduct that amount from your refund.

WELCOME

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

This contract tells you about your plan benefits and how to make the most of them. Please read this contract to find out how your health care plan works.

Some words have special meanings under your health care plan. Please see ***Definitions*** at the end of this contract.

In this contract, the words "we," "us," and "our" mean Premera Blue Cross. The words "you" and "your" mean any member enrolled in the plan. The word "plan" means your health care plan with us.

Please call us if you have any questions about this contract or your healthcare plan. We are happy to answer your questions and hear any comments. See the back cover for phone numbers and addresses.

On our website at **www.premera.com** you can also:

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

We look forward to serving you and your family. Once again, thank you again for choosing Premera.

Your Individual Benefit Plan Contract

This is your contract. The term "contract" means this document. Premera Blue Cross uses its expertise and judgment to reasonably construe the terms of this contract as they apply to specific eligibility and claims determinations. This does not prevent you from exercising rights you may have under applicable law to appeal, have independent review or bring civil challenge to any eligibility or claims determinations.

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

This coverage is issued as individual health coverage and is not sold or issued for use as a third party sponsored health plan. We do not accept payments from third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, except as required by law. We do not accept payments from business accounts, such as business credit cards or business checks, to pay for individual subscription fees.

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.

INTRODUCTION

This contract booklet is for members of Premera Blue Cross (Premera). This contract describes the benefits, exclusions and other provisions of your plan and replaces any other contract you may have received.

Right now, the Federal government is considering changes to the Affordable Care Act (ACA) that may include ending certain payments made to Premera. These payments return money to Premera to pay for Cost Share Reduction (CSR) plans. CSR plans were created by the ACA and have lower out-of-pocket costs for low-income individuals and families. If the Federal government stops the payments for CSR plans, your monthly premium for this plan will increase. You can see the rate that would be charged if this happens by going to the Office of the Insurance Commissioner's website, Insurance.wa.gov, and clicking on “Search Health Rate Increases” at the bottom of the page. You will receive 30 days' notice in advance of any rate change.

HOW TO USE THIS BOOKLET

We realize that using a health care plan can seem complicated, so we've prepared this contract to help you understand how to get the most out of your benefits.

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 **www.premera.com** you can also:

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

Every section in this booklet contains important information, but the following sections may be particularly useful to you:

- **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 the plan's prior authorization and emergency admission notifications provision
- **Clinical Review** – Describes our clinical review provision
- **Personal Health Support Programs** – Describes our personal 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 & Limitations** – 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
- **How Do I File 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
- **Other Plan Information** – Lists general information about how this plan is administered and required state and federal notices
- **Definitions** – Meanings of words and terms used

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PREMERA BLUE CROSS CASCADE SILVER

This plan uses the following network:

- ***Individual Signature*** medical network

SUMMARY OF YOUR COSTS

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

- The **allowed amount**. This is the most this plan allows for a covered service. See ***Important Plan Information*** for details. Out-of-network 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. In addition to your office visit copay, other copays may apply if you receive multiple services from the same provider during the same office visit. If the amount billed is less than the copay, you only pay the amount billed. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary.
- The **deductible**. The amount you pay 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. If any one member satisfies the individual deductible amount, this plan will begin paying for that member's covered services. When other members on the plan satisfy the family deductible, we will consider the family deductible to have been met. Then, this plan will begin paying for all family members' covered services. This type of deductible is called "embedded".

	In-Network Providers	**Out-of-Network Providers**
Individual deductible	$2,500	Not applicable
Family deductible (embedded)	$5,000	Not applicable

- The **out-of-pocket maximum**. This is the most you pay each year for services from in-network providers. If you and one or more of your dependents are enrolled in this plan, the family out-of-pocket maximum will apply. If any one member satisfies the individual out-of-pocket maximum amount, this plan will begin paying 100% of the allowed amount for that member's covered services. When other members on the plan satisfy the family out-of-pocket maximum, we will consider the family out-of-pocket maximum to have been met. Then, this plan will begin paying 100% of the allowed amount for all family members' covered services. This type of out-of-pocket maximum is called "embedded".

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$8,500	Not applicable
Family out-of-pocket maximum (embedded)	$17,000	Not applicable

- **Prior Authorization**. Some services must be authorized in writing before you get them, in order to be eligible for benefits. See ***Prior Authorization*** for details.

The conditions, time limits and maximum limits are described in this booklet. Some services have special rules. See ***Covered Services*** for these details.

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

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
Acupuncture Acupuncture treatment limited to 12 visits per calendar year, except for substance use disorder. For office visits see ***Office and Clinic Visits***.	$30 copay, deductible waived	Not covered
Allergy Testing and Treatment For office visits see ***Office and Clinic Visits***	Deductible, then 30% coinsurance	Not covered
Ambulance	$375 copay, deductible waived	$375 copay, in-network deductible waived
App-based Care App-based care select providers		
• General Medical Services	$30 copay, deductible waived	Not covered
• Mental Health	$30 copay, deductible waived	Not covered
• Substance Use Disorder	$30 copay, deductible waived	Not covered
App-based care select providers can be found at www.premera.com/visitor/virtual-care or contact Customer Service for assistance. See ***Office and Clinic Visits***, ***Mental Health Care*** and ***Substance Use Disorder*** for virtual care benefits		
Blood Products and Services	Deductible, then 30% coinsurance	Not covered
Chemotherapy and Radiation Therapy Outpatient professional and facility services	Deductible, then 30% coinsurance	Not covered
Clinical Trials You may have additional costs for other services such as x-rays, lab, prescription drugs, and hospital facility charges. See those covered services for details.	Covered as any other service	Not covered
Dental Care		
• Dental anesthesia, when medically necessary	Deductible, then 30% coinsurance	Not covered
• Dental injury You may have additional costs for other services such as x-rays, lab, and hospital facility charges. See those covered services for details.	Covered as any other service	Covered as any other service
Diagnostic X-ray, Lab and Imaging		
• Preventive care screening and tests	No charge	Not covered
• Basic diagnostic x-ray and imaging and professional services	$65 copay, deductible waived	Not covered
• Basic diagnostic lab and professional services	$40 copay, deductible waived	Not covered
• Major diagnostic x-ray, lab and imaging	Deductible, then 30% coinsurance	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
Dialysis	Deductible, then 30% coinsurance	Not covered
Emergency Room In-network and out-of-network emergency room services covered at the same cost shares		
• Facility charges and professional services You may have additional costs for other services such as x-rays, lab, and professional services. See ***Covered Services*** for details. (The copay is waived if you are admitted as an inpatient through the emergency room or if you are transferred and admitted to a different hospital directly from the emergency room.)	Deductible, then $800 copay	In-network deductible, then $800 copay
Foot Care Routine care that is medically necessary		
• Office Visits	See Office and Clinic Visits	Not covered
• Other professional services	Deductible, then 30% coinsurance	Not covered
Gender Affirming Care		
• Office and clinic visits	See Office and Clinic Visits	Not covered
• Inpatient facility and professional services	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Home Health Care Limited to 130 visits per year	$30 copay per day, deductible waived	Not covered
Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies	Deductible, then 30% coinsurance	Not covered
Hospice Care		
• Home visits (not subject to the Home Health Care visit limit)	$30 copay per day, deductible waived	Not covered
• Inpatient facility charges and professional services	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
• Respite care (limited to 14 days lifetime)		
• Inpatient Care	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
• Outpatient Care	Deductible, then 30% coinsurance	Not covered
Hospital		
• Inpatient Care		
• Facility charges and professional services	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
• Outpatient Care		

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
• Facility (Surgical)	Deductible, then $600 copay	Not covered
• Facility charges and professional services (Non-surgical)	Deductible, then 30% coinsurance	Not covered
Infusion Therapy	Deductible, then 30% coinsurance	Not covered
Mastectomy and Breast Reconstruction	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Maternity Care Prenatal, postnatal, delivery, and inpatient care. Abortion is also covered. See ***Diagnostic X-ray, Lab and Imaging***. For specialty care see ***Office and Clinic Visits***.	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Medical Foods Including phenylketonuria (PKU)	Deductible, then 30% coinsurance	Not covered
Mental Health Care		
• Office or home visits (including virtual care)	$30 copay, deductible waived	Not covered
• Other outpatient professional and facility services	$30 copay, deductible waived	Not covered
• Inpatient and residential services	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Neurodevelopmental (Habilitation) Therapy See ***Mental Health Care*** for therapies provided for mental health conditions such as autism.		
• Inpatient (limited to 30 days per calendar year)	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
• Outpatient (limited to 25 visits per calendar year)	$40 copay, deductible waived	Not covered
Newborn Care See ***Diagnostic X-ray, Lab and Imaging***. For specialty care see ***Office and Clinic Visits***.	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Office and Clinic Visits (including virtual care providers) You may have additional costs for other things such as x-rays, lab, therapeutic injections and hospital facility charges. See ***Covered Services*** for details. Add on facility charges may apply.		
• Office visits with your designated PCP. See ***How Providers Affect Your Costs***.	$30 copay, deductible waived	Not covered
• Office visit for women's health. For example gynecologist.	$30 copay, deductible waived	Not covered
• All other office and clinic visits with specialists and non-specialists (including	$65 copay, deductible waived	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
consultations with a pharmacist) See ***Mental Health Care*** and ***Substance Use Disorder*** sections for these benefits		
Pediatric Care Limited to members under age 19 **Pediatric Vision**		
• Routine exams limited to once per year	No charge	No charge
• One pair glasses, frames and lenses limited to once per year. Lens features limited to polycarbonate lenses and scratch resistant coating.	No charge	No charge
• One pair of contacts or a 12-month supply of contacts per calendar year, instead of glasses (lenses and frames)	No charge	No charge
• Contact lenses and glasses required for medical reasons	No charge	No charge
• One comprehensive low vision evaluation and four follow-up visits in a five calendar year period	No charge	No charge
• Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary	No charge	No charge
Prescription Drugs – Retail Pharmacy Up to a 30-day supply. Up to a 12-month supply for contraceptive drugs and devices. *Must use a contracted pharmacy*.		
• Preventive drugs required by federal health care reform. See ***Covered Services*** for details.	No charge	Not covered
• Contraceptives Can receive up to a 12-month supply for contraceptive drugs. *Must use contracted pharmacy*.		
• Female contraceptive drugs, devices and supplies (prescription and over-the-counter)	No charge	Not covered
• Male contraceptive drugs, devices and supplies (prescription and over-the-counter)	No charge	Not covered
• Formulary preferred generic drugs	$25 copay, deductible waived	Not covered
• Formulary preferred brand drugs	$75 copay, deductible waived	Not covered
• Formulary non-preferred drugs	Deductible, then $250 copay	Not covered
• Oral chemotherapy drugs **Your cost-shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug, and the deductible does not apply. Cost-shares for covered prescription insulin drugs apply towards the*	Deductible, then 30% coinsurance	In-network deductible, then 30% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
deductible		
Prescription Drugs – Mail-Order Pharmacy Up to a 90-day supply. *Must use a contracted pharmacy.*		
• Preventive drugs required by federal health care reform. See ***Covered Services*** for details.	No charge	Not covered
• Contraceptives Can receive up to a 12-month supply for contraceptive drugs. *Must use contracted pharmacy*.		
• Female contraceptive drugs, devices and supplies (prescription and over-the-counter)	No charge	Not covered
• Male contraceptive drugs, devices and supplies (prescription and over-the-counter)	No charge	Not covered
• Formulary preferred generic drugs	$75 copay, deductible waived	Not covered
• Formulary preferred brand drugs	$225 copay, deductible waived	Not covered
• Formulary non-preferred drugs *Your cost-shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug, and the deductible does not apply. Cost-shares for covered prescription insulin drugs apply towards the deductible	Deductible, then $750 copay	Not covered
Prescription Drugs – Specialty Pharmacy Up to a 30-day supply.	Deductible, then $250 copay	Not covered
Preventive Care		
• Exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender	No charge	Not covered
• Seasonal and travel immunizations (pharmacy, mass immunizer, travel clinic and county health department)	No charge	No charge
• Health education and training (outpatient)	No charge	Not covered
• Nicotine dependency treatment	No charge	Not covered
• Nutritional counseling and therapy	No charge	Not covered
• Female contraception management and Sterilization	No charge	Not covered
Psychological and Neuropsychological Testing	Deductible, then 30% coinsurance	Not covered
Rehabilitation Therapy See ***Mental Health Care*** for therapies provided for mental health conditions such as autism.		

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
• Inpatient (limited to 30 days per calendar year)	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
• Outpatient (limited to 25 visits per calendar year)	$40 copay, deductible waived	Not covered
Skilled Nursing Facility Care		
• Skilled nursing facility care is limited to 60 days per calendar year	Deductible, then $800 copay per day	Not covered
• Skilled nursing care in a long-term care facility is limited to 60 days per calendar year	Deductible, then $800 copay per day	Not covered
Spinal and Other Manipulations Spinal or other manipulation treatment limited to 10 visits per calendar year. For office visits see ***Office and Clinic Visits***.	$30 copay, deductible waived	Not covered
Substance Use Disorder		
• Office or home visits (including virtual care)	$30 copay, deductible waived	Not covered
• Other outpatient professional and facility services	$30 copay, deductible waived	Not covered
• Inpatient and residential services	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Surgery (includes anesthesia and blood transfusions) See ***Hospital*** and ***Surgical Center Care - Outpatient*** benefits for facility charges.	Deductible, then $200 copay	Not covered
• Male sterilization	No charge	Not covered
Surgical Center Care – Outpatient	Deductible, then $600 copay	Not covered
Temporomandibular Joint Disorders (TMJ) Care		
• Office and clinic visits	See Office and Clinic Visits	Not covered
• Inpatient facility and professional services	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Therapeutic Injections For office visits see ***Office and Clinic Visits***	Deductible, then 30% coinsurance	Not covered
Transplants		
• Office and clinic visits	See Office and Clinic Visits	Not covered
• Inpatient facility and professional services, including donor search and harvest expenses	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
• Travel and lodging. $5,000 limit per transplant. **All approved transplant centers covered at in-network benefit level*	Deductible, then 0% coinsurance	In-network deductible, then 0% coinsurance
Urgent Care		

	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
• Non-hospital urgent care centers. You may have additional costs for other services such as x-rays, lab, therapeutic injections and hospital facility charges. See ***Covered Services*** for details.	$65 copay, deductible waived	Not covered
• Urgent care centers attached to or part of a hospital *See **Mental Health Care** and **Substance Use Disorder** benefits for mental health and substance use disorder related urgent care visits*	Deductible, then $800 copay	In-network deductible, then $800 copay

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 within the Individual Signature network without referrals. However, you pay a lower office visit cost share on non-HSA plans when you designate a Primary Care Provider (PCP). You have access to one of the many providers included in your network of providers for covered services included in your plan. Please see ***How Providers Affect Your Costs*** for more information.

If a covered service is not available from an Individual Signature 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. It is still necessary for your PCP to provide a referral in this situation.

You have services for emergency services throughout the United States and wherever you may travel.

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*** benefit.

PRIMARY CARE OFFICE VISITS

This plan allows the designation of a Primary Care Provider (PCP). You pay a lower cost-share for primary care office visits on non-HSA plans by selecting a provider as your PCP and telling us the name of the PCP any time prior to an office visit. You have the right to designate any PCP in the network. Each member can select a different PCP. Children can select a pediatrician. Your PCP must be one of the following provider types:

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

You do not need a referral from your PCP or any other person authorizing access to specialty care. This includes but is not limited to gynecologists and obstetricians. However, there may be services provided by the specialist that require prior authorization. Please see ***Prior Authorization*** for details.

We encourage you to select a PCP at the time you enroll in this plan. If you have difficulty locating an available PCP, contact us and we will help you in selecting one. If you do not choose a PCP, we may assign as your PCP a provider you have previously seen. You may change this PCP selection by contacting us. If your PCP is part of a group practice, you can see any provider type listed above in that practice, and pay the PCP office visit cost-share.

You can change your PCP selection at any time by contacting us, but the change will be effective the first of the next month.

If you need to see your PCP and your PCP is not available, you may see a PCP within the same clinic and you will only be responsible for the lower cost share. If your PCP is a sole practitioner, you may see a PCP that your provider has asked to cover in their absence. You will only be responsible for the lower cost-share.

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

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

CALENDAR YEAR DEDUCTIBLE

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

Individual Deductible

This plan includes an individual deductible. After you pay this amount, this plan will begin paying for your covered services.

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

Family Deductible

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

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

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

Deductibles are subject to the following:

- Deductibles accrue during a calendar year and begin each year on January 1
- There is no carry over provision. Amounts credited to your deductible during the current year will not carry forward to the next year's deductible
- Amounts credited to the deductible will not exceed the allowed amount
- Amounts credited toward the deductible do not add to benefits with a 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

Copayments ("copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service. If the amount billed is less than the copay, you only pay the amount billed.

Inpatient Care Copay The inpatient care copay is a per-day copay with a limit of five days/copays per admission maximum. For example, you will pay two copays for a two-day inpatient stay at a hospital. However, if your stay is longer than five days, you will only have to pay five copays.

Office Visits and Other Services Copay You pay this copay for each office visit and any other services subject to a copay. Separate copays may apply for multiple services provided by the same provider. Separate copays will also apply if you see more than one provider on the same day.

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

COINSURANCE

Coinsurance is a percentage of healthcare costs you are responsible for. You start paying coinsurance after you pay your deductible. Your coinsurance amount for this plan is shown on the ***Summary of Your Costs***.

See ***Summary of Your Costs*** for your coinsurance amount.

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 ***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 ***Summary of Your Costs*** for the name of your provider network.

Out-of-Network

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

- An amount that is no less than the lowest amount we allow 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 as implemented by Premera
- The provider's billed charges

There is one exception: The allowed amount is the provider's billed charge for emergency services by a ground ambulance that does not have a contract with us or the local Blue Cross Blue Shield Licensee.

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

Non-Emergency Services Protected From Balance Billing

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

Emergency Services

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

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

Note: Non-participating ground 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.

Air Ambulance

The allowed amount for non-participating air ambulance providers will be calculated consistent with the requirements of federal law.

Providers Outside Washington

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*** described below, 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 in-network providers,

you're responsible only for any deductible, copays, or coinsurance required by this plan.

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 Individual Signature network without referrals. If a covered service is not available from an Individual Signature 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. It is still necessary for your PCP to provide a referral in this situation.

You may receive services for emergency services throughout the United States and wherever you may travel.

A list of in-network providers is available in our Individual Signature provider directory. These providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. Our provider network includes providers in all counties in the state of Washington.

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

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

Our provider directory is available any time on our website at **www.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 provide medical services for a negotiated fee. This fee is the allowed amount for in-network providers.

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

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

Contracted Health Care Benefit Managers

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

Non-Participating Providers

Non-participating providers are either (1) providers that are not part of your network (out-of-network) or (2) providers that do not have a contract with us (non-contracted). Generally, non-participating providers are not covered on your plan. However, if a covered service is not available from an in-network provider, you can receive benefits for services provided by a non-participating provider. See ***Prior Authorization*** for details.

When a service is covered by a non-participating provider, the provider may bill you for charges above the allowed amount. You may also be required to submit the claim yourself. See ***How Do I File A Claim*** for details.

- **Out-of-network providers.** In some cases, an out-of-network provider may have a contract with us, but is not part of your network. Because these providers are not part of your network, most services from these providers will not be covered. In the event the services are covered (See ***Benefits for Out-of-Network or Non-Contracted Providers***), contracting providers will not bill you for amounts over the allowed amount.
- **Non-contracted providers. Non-contracted** providers do not have a contract with us or with any of the other networks used by this plan.

Balance Billing Protection

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

Emergency Services from a non-participating hospital or facility or from a non-participating provider at the hospital or facility.

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

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

Air Ambulance

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

For the above services, you will pay no more than the plan's in-network cost-shares. See ***Summary Of Your Costs***. Premera Blue Cross will work with the non-participating provider to resolve any issues about the amount paid. Premera will also send the plan's payments to the provider directly.

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

Benefits for Out-of-Network or Non-Contracted Providers

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

- Emergency services for a medical emergency. (Please see ***Definitions*** section for definitions of these terms.) This plan provides worldwide coverage for emergency services.
- The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services has a contract with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.
- Covered services from certain categories of providers to which provider contracts are not offered. These types of providers are generally not listed in the provider directory.
- Facility and hospital-based provider covered services received from a hospital that has a provider contract with us.

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

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 must get prior authorization in order for an out-of-network provider to be covered by the plan, except for emergency services. Please see ***Exceptions To Prior Authorization For Out-of-Network Providers*** below for more information.

How Prior Authorization Works

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

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

Our prior authorization will be valid for 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.

- **Premera providers or facilities** are required to request prior authorization for the service.
- **Out-of-network providers or facilities and all providers and facilities outside Washington and Alaska** 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 **www.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 **www.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.

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

- A set number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis
- Certain drugs from certain pharmacies, or you may need to get a prescription drug from an appropriate medical specialist or a specific provider.
- Step therapy, meaning you must try a generic drug or a specified brand name drug first
- Drug synchronization, meaning the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for

a given time period. Cost-shares are adjusted if the fill is less than the standard refill amount in compliance with state law.

These limits are based on medical standards, the drug maker's advice, and your specific case. They are also based on FDA guidelines and medical articles and papers.

Exceptions To Prior Authorization 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 services 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.

2. Prior Authorization For Out-Of-Network Provider Coverage

Generally, out-of-network providers are not covered by your plan except for emergency services. However, you 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 the out-of-network provider must ask for prior authorization before you receive the services.

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 may 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 services 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.

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 **www.premera.com**.

PERSONAL HEALTH SUPPORT PROGRAMS

Premera 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 ID card.

CONTINUITY OF CARE

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

COC applies in these situations:

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

How you qualify for Continuity of Care You may qualify if you are in an "active relationship" or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy
- Are receiving treatment for a terminal illness

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

You can request continuity of care by contacting customer service. 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 earliest of the following:

- The 90th day after we notified you that your Primary Care Provider (PCP)'s contract ended
- The day after you complete the active course of treatment entitling you to continuity of care
- If you are pregnant, and become eligible for continuity of care after commencement of the second trimester of the pregnancy, you will receive continuity of care

Continuity of care does not apply if your provider:

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

When continuity of care ends, you may continue to receive services from this same provider, however, we will pay benefits at the out-of-network benefit level. Please see ***How Providers Affect Your Costs*** for more information. 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 service means medically necessary services (See ***Definitions***) and specified preventive care services you get when you are covered for that benefit. This plan provides benefits for covered services only if all of the following are true when you get the services:

- The reason for the service is to prevent, diagnose or treat a covered illness, disease or injury

- The service takes place in a medically necessary setting. For more information about what medically necessary means, see ***Definitions***.
- The service is not excluded
- The provider is working within the scope of their license or certification

This plan may exclude or limit benefits for some services. See the specific benefits in this section and the ***Exclusions & Limitations*** 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. See ***Prior Authorization*** section for more information.
- Medical and payment policies. The plan has policies that are used to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigative status for a specific procedure, drugs, biologic agents, devices, and level of care or services. Payment policies define provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at **www.premera.com** 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 on the back cover.

COMMON MEDICAL SERVICES

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

Acupuncture

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

This benefit covers acupuncture to:

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

Allergy Testing and Treatment

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

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:

- Transport takes you to the nearest available facility that can treat your condition
- The above requirements for ambulance services are met
- Geographic restraints prevent ground transport, and
- Ground emergency transportation would put your health or safety at risk

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

This benefit does not cover:

- Services from an unlicensed ambulance

App-based Care

On demand virtual care that connects you to providers via an application (app) software program. Benefits are provided for services for low-level medical conditions using virtual methods like secure chat, text, voice or video chat. App-based care select providers can be found at www.premera.com/visitor/virtual-care or contact Premera Customer Service for assistance.

Blood Products and Services

- Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider.
- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.

Chemotherapy and Radiation Therapy

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

Chemotherapy and radiation must be prescribed by a doctor and approved by Premera to be covered. See ***Prior Authorization***.

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit
- Supplies, solutions and drugs
- Tooth extractions needed to prepare your jaw for radiation therapy

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 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 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 doesn't cover:

- Costs for treatment that aren't primarily for your care (such as lab tests performed just to collect information 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 isn't consistent with established standards of care for a certain condition
- Services, supplies or drugs that would not be charged to you 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 Injury 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.

Benefits are based on the type of service you get. For example, if you have 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 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. For more information about what services are covered as preventive see ***Preventive Care***.

A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

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
- Diagnosis and treatment of the underlying medical conditions that may cause infertility

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:

- Emergency Room
- Hospital
- Maternity Care
- Preventive Care
- Genetic testing may be covered in some cases. Call Customer Service before seeking testing since it may require Prior Authorization.

Testing required for employment, schooling, screening, or public health reasons that are not for the purpose of treatment is not covered.

Dialysis

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

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 ***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, including mental health or substance use disorder. 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.

Foot Care

This benefit covers the following medically necessary foot care services that require 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 doesn't cover routine foot care such as trimming nails or removing corns and calluses that do not need care from a doctor.

Gender Affirming Care

Benefits for medically necessary gender affirming care 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*** earlier in this booklet.

Benefits are provided for all gender affirming care surgical services which meet the criteria of the Premera medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from Customer Service, or at www.premera.com.

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of gender affirming care 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.

Home Health Care

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

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

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

General Home Health Care

General Home Health Care is short-term care performed at your home. These occasional visits are done by a medical professional that's employed through a home health agency that is state-licensed or Medicare-certified. Care is covered when a doctor states in writing that care is needed in your home.

The following are covered under the Home Health Care benefit:

- 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 respiratory therapist
- A certified speech therapist
- A home health aide directly supervised by one of the above listed providers
- A social worker

Skilled Hourly Nursing

Skilled Hourly Nursing is also covered under the Home Health Care benefit. Skilled Hourly Nursing is medically intensive care at home that is provided by a licensed nurse.

Skilled Hourly Nursing is covered only when provided in lieu of hospitalization.

You must have a written plan of care from your doctor and requires prior authorization by the plan. See ***Prior Authorization***. This type of care is not subject to any visit limit shown in the ***Summary of Your Costs***.

The Home Health Care benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Private Duty Nursing that is not General Home Health Care or Skilled Hourly Nursing
- 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 the following medical eye conditions:

- Aniridia
- Aniseikonia
- Anisometropia
- Corneal disorders
- Corneal ulcer
- Bullous keratopathy
- Recurrent erosion of cornea
- Tear film insufficiency
- Aphakia
- Sjogren's disease
- Congenital cataract
- Corneal abrasion
- Irregular astigmatism
- Keratoconus
- Pathological myopia

- Post-traumatic disorders
- Progressive high (degenerative) myopia

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

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 ***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
- Non-medical 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 not have to pay any amounts over the allowed amount for covered services.

You pay out-of-network cost-shares if you get care from a provider not in your network. You will not be balanced billed for certain services provided by a non-participating provider. 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

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

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
- 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. 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:

- Donor breast milk
- Outpatient x-ray, lab and imaging. These services are covered under ***Diagnostic X-ray, Lab and Imaging***.
- Depression screening for pregnant and postpartum members are covered as preventive services. See the ***Preventive Care*** benefit.

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.

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

Medical foods must be prescribed and supervised by doctors or other health care providers.

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

Mental Health Care

This benefit covers diagnosis and treatment of a mental condition (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. Please call Customer Service for help in finding a physician approved to provide these services.

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

This benefit covers all of the following services:

- Inpatient, residential treatment and outpatient care (including virtual 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
- Physical, speech or occupational therapy for mental health conditions, such as autism spectrum disorders
- 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.)
- A state-licensed community mental health agency or behavioral health agency
- Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care.

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. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.
- A therapy assistant/behavioral technician/paraprofessional, when their services are supervised and billed by a licensed provider or a BCBA.

The Mental Health Care benefit does not cover:

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 ***Mental Health Care*** and ***Substance Use Disorder*** benefits.

Please see ***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 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 obstetrical care benefits under this plan.

To continue benefits beyond the 3-week period, please see the dependent eligibility and enrollment guidelines outlined under ***Eligibility and Enrollment***.

This benefit covers:

- Nursery services and supplies for 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, home visits, and real-time visits via online and telephonic methods (virtual care) 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.

Please call Customer Service for help in finding a physician approved to provide these services.

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, facility fees, office surgeries and medical equipment and supplies. Some outpatient services you get from a specialist must have prior authorization. See ***Prior Authorization*** for details. See ***Urgent Care*** for 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 Vision

Coverage for routine eye exams and glasses for members under 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 prior authorization. See ***Prior Authorization*** for details.

Benefits available under this plan will be provided for “off-label” use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by one of the following:

- One of the following standard reference compendia:
  - **The American Hospital Formulary Service-Drug Information**
  - **The American Medical Association Drug Evaluation**
  - **The United States Pharmacopoeia-Drug Information**
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

“Off-label use” means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

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

FDA.

Prescription Drug Formulary

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

The formulary includes both generic and brand name drugs. Consult the Pharmacy Benefit Guide or RX Search tool listed on our website, 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 a 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 for 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 the medical and other relevant information. There is no cost to you for this review.

We will let you and your provider know the IRO's decision within 72 hours (24 hours in the case of an expedited review). If the IRO grants your request for an exception, your cost will be as shown 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 all drug ingredients require a prescription
- 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 that are required to be covered by state or federal law, such as diaphragms and cervical caps are covered when provided by an in-network pharmacy, see ***Prescription Drugs*** in the ***Summary of Your Costs***
- Over-the-counter (OTC) drugs that are required to be covered by state or federal law

Pharmacy Management

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

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

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

Dispensing Limits

Benefits are limited to a certain number of days' supply as shown in 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 website 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 website at **www.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 ***How Do I File A Claim*** for instructions.

This plan does not cover prescription drugs from out-of-network pharmacies.

Specialty Pharmacy Programs

The Specialty Pharmacy Program includes drugs that are used to treat complex or rare conditions. These drugs need special handling, storage, administration, or patient monitoring. This plan covers these drugs as shown in 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 **www.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 such as infant formulas or protein 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. See Infusion Therapy for covered infusion therapy services.
- 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
- 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 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 80% of a supply of a single medication. The 80% is calculated based on both of the following:

   - The number of units and days' supply dispensed on the last refill
   - The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill

7. **What other pharmacy services does my health plan cover?**

   This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by a licensed participating pharmacy. Other services, such as diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

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 **www.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 members
- Routine exams and well-baby care. Included are exams for school, sports and employment
- Preventive services, tests, screening and supplies as recommended by the HRSA women’s preventive services guidelines.
    - Services such as breast feeding counseling before and after delivery, maternity diagnostic screening and diabetic 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 How Do I File A Claim for instructions.
- 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 45 years of age, all individuals 45 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.
- Colonoscopies as follow-up to a positive non-invasive stool-based screening test
- 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 ***How Do I File 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 a 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 or at an in-network pharmacy, including all FDA approved contraceptives that

are required to be covered by state or federal law. FDA approved contraceptives include, but are not limited to emergency contraceptives, and contraceptive devices (insertion and removal). Tubal ligation is 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.
- Pre-exposure (PrEP) for members at high risk for HIV infection.
- 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 **www.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
- Male sterilization. See ***Surgery***.

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 retesting 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 ***Mental Health Care*** and ***Substance Use Disorder*** benefits. Also, see the ***Neurodevelopmental (Habilitation) Therapy*** benefit.

Chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases are covered as any other medical condition and do not accrue to rehabilitation therapy limits.

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 doctor

Outpatient Care

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

- 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 fist 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.
- 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

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 ***Rehabilitation Therapy*** and ***Neurodevelopmental (Habilitation) Therapy*** benefits.

Substance Use Disorder

This benefit covers diagnosis and treatment for substance use disorder (See ***Definitions***). You must 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. Please call Customer Service for help in finding a physician approved to provide these services.

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 (including virtual 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 therapy
- Family or group therapy as required by law
- Lab and testing

- Take-home drugs you get in a facility

To be covered, treatment 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), advance 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 (Ph.D.)
- A state-approved substance abuse treatment program
- A state-licensed community mental health agency or behavioral health agency

Substance Use Disorder benefit does not cover:

- Testing that is not used to assess a covered substance use disorder or plan treatment. This benefit does not cover drug or alcohol testing done for school or employment.
- Halfway houses, quarter way houses, recovery houses and other sober living residences

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 an underlying medical cause of infertility. **Please Note:** Benefits are not provided for assisted reproductive techniques, or sterilization reversal
- Surgical supplies
- Reconstructive surgery that is needed as a direct result of an injury, infection or other illness.
- The repair of a dependent child's congenital anomaly
- Cosmetic surgery for correction of functional disorders. This does not include removal of excess skin and or fat related to weight loss surgery or the use of weight loss drugs.
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes
- Male sterilization/vasectomy

This benefit does not cover:

- Breast reconstruction. See ***Mastectomy and Breast Reconstruction*** for those covered services.
- 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.

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

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

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

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 require prior authorization 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***)

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 Premera 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 only covers 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.

Artificial organ transplants are covered based on your doctor's medical guidelines and the manufacturer recommendations.

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. These procedures are covered the same way as other covered surgical procedures.

Recipient Costs

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

Covered services consist of all phases of treatment:

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

Donor Costs

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

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

Transportation and Lodging

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

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

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

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

- Adult Patient – 1 companion is permitted.

- Child Patient – 2 parents or guardians are permitted

Non-Covered Expenses

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

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.

EXCLUSIONS & LIMITATIONS

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

Amounts Over the Allowed Amount

Costs over the allowed amount as defined by this plan for a non-emergency service from a non-contracted provider.

Assisted Reproduction

Assisted reproduction technologies, such as:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures
- Artificial insemination or in-vitro fertilization
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

Benefits from Other Sources

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 homeowners' 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

Caffeine Dependence

Charges for Records or Reports

Charges from providers for supplying records or reports not requested by Premera for utilization review.

Comfort or Convenience

- Personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV and personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport.
- Meal 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, but see the ***Emergency Room*** benefit.

Cosmetic Services

Drugs, services or supplies for cosmetic services.

- Job help and outreach
- Social or fitness counseling
- Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff
- Private school or boarding school tuition

Court-Ordered Services

Services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Custodial Care

This plan does not cover custodial care.

Dental Care

This plan does not cover dental care that is not medically necessary.

EEG biofeedback or neurofeedback services

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental and Investigative Services

Experimental or investigative services or supplies. This plan also does not cover any complications or effects of such services.

Family Members or Volunteers

Services that you provide 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

Government Facilities

This plan does not cover services provided by a non-contracted state or federal facility that are not emergency services unless required by law or regulation.

Hair Analysis

Hair Loss

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

Hearing Exams

This plan does not cover routine hearing exams and testing used to prescribe or fit hearing aids and any associated service or supply.

Hearing Hardware

This plan does not cover hearing aids and devices used to improve hearing sharpness and any associated service or supply.

Illegal Acts, Illegal Services, and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.

Laser Therapy

Low-level laser therapy.

Military Service and War

Illness or Injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, National Guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

Non-Covered Services

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 the ill or injured member. This includes health care provider training or educational services.
- 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.
- Arrangements in which the provider lives with the member

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing
- Incarceration
- Programs from facilities that are not licensed to provide treatment for covered services.

Examples are prisons, nursing homes and juvenile detention facilities.

Orthodontia

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

Orthognathic Surgery

Procedures to lengthen or shorten the jaw (orthognathic surgery), regardless of the origin of the condition that makes the procedure necessary.

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.

Recreational, Camp and Activity Programs

Recreational, camp and activity-based programs. These programs include:

- Gym, swim and other sports programs, camps and training
- Creative art, play and sensory movement and dance therapy
- Recreational programs and camps
- Hiking, tall ship and other adventure programs and camps
- Boot camp programs and outward-bound programs
- Equine programs and other animal-assisted programs and camps
- Exercise and maintenance-level programs

Serious Adverse Events and Never Events

Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. 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) website at **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.

Services or Supplies Not Medically Necessary

Services or supplies that are not medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care.

Sexual Dysfunctions

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

Vision Exams

This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware for members 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 for members 19 and older. This plan never covers

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, treatment or surgeries to improve the refractive character of the cornea, or results these treatments.

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 for weight loss or weight control.

Work-Related Illness or Injury

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

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

OTHER COVERAGE

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

COORDINATING BENEFITS WITH OTHER PLANS

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

If you do not know which 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 plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.

- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See ***Effect on Benefits*** later in this section for rules on secondary plan benefits.
- **Allowable expense** is a healthcare expense, including deductibles, coinsurance and copays, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that is not covered by any of your plans is not an allowable expense.

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

  The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.
- **Gatekeeper requirements** Any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. Examples are restrictions of coverage to providers in a network, prior authorization, or primary care provider referrals.

Primary and Secondary Rules

A plan that does not have a COB provision that complies with Washington regulations is primary to a complying plan unless the rules of both plans make the complying plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

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

Non-dependent or dependent The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.

Dependent children Unless a court decree states otherwise, the rules below apply:

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child's healthcare expenses or coverage, that plan is primary. This rule applies to calendar years starting after the plan is given notice of the court decree.
  - If a court decree assigns one parent primary financial responsibility for the child but does not mention responsibility for healthcare expenses, the plan of the parent with financial responsibility is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, then that plan is the primary plan.
  - If a court decree makes both parents responsible for the child's healthcare expenses or coverage, the birthday rule determines which plan is primary.
  - If a court decree requires joint custody without making one parent responsible for the child's healthcare expenses or coverage, the birthday rule determines which plan is primary.
  - If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
    - The plan covering the custodial parent, first
    - The plan covering the spouse of the custodial parent, second
    - The plan covering the non-custodial parent, third

- The plan covering the spouse of the non-custodial parent, last
- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

Retired or Laid-off Employee The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

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

Please Note: The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

Length of Coverage The plan that covered you longer is primary to the plan that didn't cover you as long.

If none of the rules above apply, the plans must share the allowable expenses equally.

COB's Effect on Benefits

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

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. **The total amount paid by the secondary plan in combination with the primary plan payment will not be more than one hundred percent of the highest total allowable expense of either plan in addition to any savings accrued from prior claims incurred in the same calendar year.**

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

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

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

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

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

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

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

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 tortfeasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss.

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

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

HOW DO I FILE 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 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.

Special Notice about Claim Procedure

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

COMPLAINTS AND APPEALS

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

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

What is a Complaint?

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

How to file a complaint

Call customer service at 1-800-607-0546
Send a fax to 866-903-9899

Send the details in writing to:
Premera Blue Cross
PO Box 21702
Eagan, MN 55121

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

What is an Appeal?

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

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

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

What you can appeal

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.
Enrollment canceled or not issued	No Coverage	You are not eligible to enroll or stay in the plan

Appeal Levels

You have the right to two levels of appeals:

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

How to Submit an Appeal in Writing

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on **www.premera.com** or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **www.premera.com**. We can’t release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross PO Box 21702 Eagan, MN 55121 Fax to 866-903-9899

Note: You may also call customer service to verbally submit an appeal.

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

Premera Blue Cross
PO Box 21702
Eagan, MN 55121

Fax: 866-903-9899

Appeal Response Time Limits

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

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

If we need more time

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

What if you have ongoing care?

Ongoing care is continuous treatment you 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 if it's urgent?

If your condition is urgent, you will get our response sooner. 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 services 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

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

Step 1. **Get the form**	**We'll tell you about your right to an external review with the written decision of your internal appeal.** • Complete the Independent Review Organization (IRO) Request form, you can find it on **www.premera.com** or call customer service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
Step 3. **Send in my external review request**	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross PO Box 21702 Eagan, MN 55121 Fax to 866-903-9899

Note: You may also call customer service to verbally submit an external review request.

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

Once the IRO decides

For urgent appeals, the IRO will inform you and 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**

ELIGIBILITY AND ENROLLMENT

General Eligibility Requirements

Enrollment and maintenance of coverage on this contract is contingent on the individuals meeting all of the following requirements:

- They must have completed a Premera enrollment application that includes appropriate signatures and initials or have enrolled through the Washington Health Benefit Exchange (The Exchange).
- They are residents of Washington state.

- “Resident” means a person who lives in Washington State and intends to remain in the state permanently or indefinitely. In no event will coverage be extended to a subscriber or dependent who resides in the state for the primary purpose of obtaining health care or health care coverage. The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Examples of proof include, but shall not be limited to a valid photo ID, utility bills, tax or financial records; all documents must show the street address of the individual's residence and not a post office box.
- Their principal residence is located within our service area
- They are not entitled to (enrolled in) Medicare on the date coverage would begin
- They are not 65 years of age or older, and eligible for Medicare on the date coverage would begin

The individuals defined below are eligible to enroll on this contract.

- The subscriber. Individuals can only apply during an open enrollment or special enrollment period (See ***Open Enrollment Period*** and ***Special Enrollment Period***.
- The lawful spouse of the subscriber. For purposes of the rights and benefits of this plan, the term “spouse” also means 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.”
- A dependent child who is under 26 years of age, except as provided in the ***Continued Eligibility for a Disabled Child*** section. 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 legal dependent or foster child of the subscriber or spouse. There must be a court order or other 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.
  - A child for whom the subscriber or spouse is required by a medical child support order to provide health coverage

Open Enrollment Period

Families and individuals who wish to enroll in a Premera plan and or to enroll for coverage as a dependent on an existing plan may apply only during an open enrollment period. The only exception is for existing dependents transferring to an identical contract as stated in ***Continuation of Coverage on an Identical Contract*** or if you are enrolling a natural newborn or adoptive child whose date of birth or date of placement is after the subscriber's effective date of coverage on this plan. In this instance, you must submit the application within 60 days of birth or placement for adoption, or a qualifying loss of coverage event.

We must receive a completed enrollment application before the end of the open enrollment period. See ***When Coverage Begins*** for information on effective dates. If the application is not received within the open enrollment period, applicants cannot apply for enrollment until the next open enrollment period.

Special Enrollment Period

Qualifying Events

Individuals who don't enroll in this plan during a designated open enrollment period may later enroll in this plan outside of an open enrollment period only if one of the following is met:

- Birth of a newborn child
- Marriage or entering into a domestic partnership, including eligibility as a dependent
- Placement for adoption of a child of the subscriber or enrolled spouse, also applies to children placed in foster care
- Loss of employer sponsored coverage
- A loss of Medicaid or other public program providing health benefits

- A loss of coverage due to a dissolution of marriage or termination of domestic partnership
- A loss of coverage due to a change in residence and your existing health plan does not provide coverage in your new area.
- Loss of COBRA benefits.
- Loss of coverage on The Exchange, due to an error by The Exchange, the issuer or HHS
- 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

Enrollment is subject to verification at the time of application. Please see **www.premera.com** or if you enrolled through The Exchange, contact The Exchange for information on required documentation for your qualifying event.

When we receive your completed enrollment application, required documentation and any required subscription charges within 60 days of the qualifying event, coverage under this plan will become effective on the first of the month following receipt of your enrollment application or we are notified of enrollment by The Exchange.

If we don't receive your completed enrollment application within 60 days of the date of the qualifying event, please see ***Open Enrollment Period***.

When Coverage Begins

Subscriber and Existing Dependents

If you enrolled through The Exchange, your coverage will begin as of the effective date established by The Exchange.

If you enrolled directly with us, initial coverage on this plan will become effective as follows:

- For applications received by the 14th day of the month, coverage will be effective on the 15th day of that month. In this instance, a pro-rated subscription charge will be applied for the first partial month of coverage.
- For applications received between the 15th and the last day of the month, coverage will be effective on the first day of the following month.

The receipt date will be the date of postmark or the date of delivery to us, whichever is earlier.

New Dependents

You must submit your enrollment request for new dependents to us or The Exchange timely. The effective date of coverage will be determined by the receipt date of your approved application and required subscription charges.

An enrollment application isn't required when subscription charges being paid for dependents already include coverage for additional new dependent children, but we may request additional information if necessary to establish eligibility of dependent children.

Newborn Children

Newborn children are automatically covered for the first 3 weeks from birth when the mother is covered on the plan. Beyond the first 3 weeks, you must submit an application to us or contact The Exchange to enroll the child. The child may be enrolled as a dependent under a current subscriber or on their own plan as a single subscriber. The effective date will be the child's date of birth **only** if we receive a completed application within 60 days of birth. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Adoptive Children

The effective date will be the date of placement with the subscriber **only** if application to us or The Exchange is received timely. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Domestic Partners and Their Children

Coverage will be effective for the domestic partner and/or their children upon our acceptance and approval of the completed application or notification of enrollment through The Exchange and payment of required subscription charges as described under ***When Coverage Begins***.

Legal Guardianship

Children who are legal dependents of the subscriber or spouse and meet all stated eligibility requirements will be accepted for coverage when we receive the completed application or notification of enrollment through The Exchange and copies of the final court-ordered guardianship.

The effective date will be the date of the guardianship order if the approved application is received within 60 days of that date. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Medical Child Support Orders

An application must be submitted to us or enrollment through The Exchange, along with a copy of the medical child support order. The application may be submitted by the subscriber, the child's custodial parent, or a state agency administering Medicaid. The effective date will be the date of the order **only** if the application is received within 60 days of the date of the order. Otherwise, coverage will become effective as stated under ***General Eligibility Requirements***.

Due To Marriage

The effective date will be the date of marriage **only** if the approved application is received or enrollment is done through The Exchange within 60 days of the date of the marriage. Otherwise, coverage will become effective as described under ***General Eligibility Requirements***.

Other Provisions Affecting Coverage

Term of Contract

This contract is guaranteed renewable except as stated under ***When Coverage Ends***.

Subscription Charges and Grace Period

This contract is issued in consideration of an accepted application or notification of enrollment through The Exchange and the payment of the required subscription charges. Subscription charges are not accepted from third party payers including employers, providers, non-profit or government agencies, except as required by law.

Federal Government Assistance with Subscription Charges: If the federal government is paying a portion of your subscription charge as an advance payment of the premium tax credit, you have a different grace period to pay your portion of the subscription charges. If we receive an advance payment of premium tax credit from the government for you, you have up to a three month grace period to pay all outstanding subscription charges.

- For the first month of the three month grace period, we will continue to process and pay claims for covered services under this plan.
- Beginning on the first day of the second month and through the last day of the third month, we will pend all your claims.

  If we have not received all outstanding subscription charges by the last day of the third month, this contract will, without further notice, terminate as of the last day of the first month of the grace period. We will also deny all pended claims for services you received in the second and third months of the grace period. Note that providers can then seek reimbursement directly from you for those services, and they would not be considered covered under this plan.

  If after termination you wish to re-enroll on an individual plan offered by us or one of our related companies, we reserve the right to require you to pay any unpaid subscription charges that were due during the 12 month period prior to your re-application for coverage.

No Federal Government Assistance with Subscription Charges: For members whose subscription charges are not subsidized by the federal government, you have a 1 month grace period to pay subsequent subscription charges. If a payment is not received by the end of the grace period, your coverage will terminate as of the last day of the period for which subscription charges were paid. Claims for services received after the termination date will be denied. Providers can seek reimbursement directly from you for those services.

Consistent with state law, we reserve the right to revise subscription charges annually upon written notice (See ***Notices***). Such notice will be provided to the subscriber. Such changes will become effective on the date stated in the notice, and payment of the revised subscription charges will constitute acceptance of the change.

Subscription charges will also be revised in the following situations:

- A change in the number of enrolled dependents, except when subscription charges being paid for dependent children already include additional dependent children.

- The subscriber enrolls in a different Premera individual dental plan.
- A change in government requirements affecting the health plan, a mandated change in benefits, eligibility or other plan provisions, or imposition or changes to an assessment or tax on our revenue.

Subscription charges may also be adjusted outside of the plan renewal when the federal or state government requirements that affect the plan are changed, such as the government ceasing payments to us for advance premium tax credits, cost share reduction payments, or other monies owed to Premera.

TERMINATION

When Coverage Ends

Coverage under this contract is guaranteed renewable and will not be terminated, except as described below.

Termination by the Subscriber

The **subscriber** may terminate this contract by:

- Contacting us or The Exchange, (if you enrolled through The Exchange). For coverage purchased directly from us, termination will be effective on the last day for which subscription charges were paid.
- Failing to pay the required subscription charges when due or within the grace period

Termination by Us

Coverage under this contract will terminate when any of the events specified below occurs.

- Nonpayment of subscription charges. Coverage will end without notice as of the last date for which subscription charges were paid.
- Violation of published policies of Premera that have been approved by the Washington State Insurance Commissioner
- A member no longer lives in Washington State
- A member commits fraudulent acts as to Premera
- A member materially breaches the contract which includes, but is not limited to, failure to continue to meet the provisions stated under ***General Eligibility Requirements***
- Change or implementation of federal or state laws that no longer permit the continued offering of this contract
- We discontinue this contract to all those covered under this contract as allowed by law. In such instance you will be given at least a 90-day notification of the discontinuation. If we discontinue this contract, you may apply for any other individual plan currently offered for sale by us or The Exchange.
- We withdraw from a service area or from a segment of a service area as allowed by law
- Any other reason allowed by state or federal law

In the event this coverage under this contract is terminated, Premera will refund any subscription charges received for dates beyond the contract termination date stated in our notice to you (See ***Notices***).

Continuation of Coverage

Continued Eligibility for a Disabled Child

Coverage may continue past the limiting age for an unmarried dependent child who is incapable of self-sustaining employment by reason of a developmental or physical disability and who is chiefly dependent upon the subscriber for support and maintenance.

The child will continue to be eligible if all of the following are met:

- The subscriber is covered under this plan
- The child became disabled before reaching the limiting age
- Within 31 days of the date the child no longer meets dependent child eligibility requirements, the subscriber furnishes proof of the child's disability and dependency acceptable to us
- The child's subscription charges, if any, continue to be paid

The subscriber provides proof of the child's disability and dependent status when we request it. We will not ask for proof more often than once a year after the two-year period following the date the child qualifies for continuing eligibility.

Continuation of Coverage on an Identical Contract

Dependent(s) may continue coverage on an identical contract in the following situations:

- If the subscriber terminates coverage for any reason, or in the event of death of the subscriber or divorce of the subscriber and spouse, enrolled dependents under this plan may continue under an identical contract. The dependent(s) must meet all of the eligibility requirements as specified in this contract. If the spouse continues coverage, the spouse's enrollment status will change from dependent to subscriber and any enrolled child may be covered under the spouse's continued coverage. Subscription charges will be assessed at the appropriate rate. If there is no spouse, or the spouse does not continue coverage, each enrolled child may continue coverage as a subscriber, and subscription charges will be assessed at the appropriate subscriber rate.
- A dependent child, who no longer is eligible as a dependent under this contract for reasons such as reaching the maximum dependent age, may continue coverage on an identical contract as a subscriber, providing all eligibility requirements, as specified in this contract, are met. The child's enrollment status will change from dependent to subscriber, and subscription charges will be assessed at the appropriate subscriber rate.

To continue coverage, an enrollment application must be submitted to us or you must contact The Exchange prior to the date coverage would end as a dependent.

OTHER PLAN INFORMATION

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.

Changes To Benefits and Subscription Charges

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 ***Notices***).

Your subscription charges will change as follows:

- When you have a change in your family and add or delete family members
- When you move to a new rate area. This change will be effective the first day of the month following your move to a new rate area.
- When a member resumes tobacco use, we also reserve the right to change the subscription charge for a member who is getting a non-tobacco user's discount, to the full undiscounted rate. This change will be effective the first day of the month following the date the member resumes tobacco use.

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 over the signature of an officer of Premera.

Conformity with the Law

This 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 preempted by federal law. In the event any provision of the contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the 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 you and Premera consists of all of the following:

- The contract
- All applications used to apply for coverage
- All attachments and endorsements included now or issued later

Evidence of Medical Necessity

We have the right to require proof of medical necessity from a member receiving benefits under this contract. You or your providers may submit such proof. No benefits will be available under this contract if the proof is not provided or acceptable to us.

Health Care Providers - Independent Contractors

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

ID Card

If you need a replacement Premera ID card, call our customer service or visit our website at **www.premera.com**. If coverage under the contract terminates, your Premera ID card will no longer be valid.

Independent Corporation

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

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.

Individual Medical Plan

This contract is sold and issued in Washington State as an individual medical plan. It is not issued for use as an employer-sponsored or group health plan. Premera specifically disclaims any liability for state or federal group plan requirements.

This contract does not replace, affect, or supplement any state or federal requirement for worker's compensation, employer's liability, or similar insurance. When an employer is required by law to provide or has the option to provide worker's compensation or similar insurance and does not provide such coverage for its employees, the benefits available under this plan will not be provided for conditions arising out of the course of employment which are or would be covered by such insurance.

Intentionally False or Misleading Information

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 form required by us, that affect the acceptability of the Member or the risks to be assumed by us, may cause the 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.

Limitation 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

Nonwaiver

No delay or failure when exercising or enforcing any right under this contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this contract shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

Notices

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 will be the delivery date.

If you are required to send notice to us, the postmark date will be the delivery date. If it is 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, health care providers, insurance companies, or other sources.

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

- Determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the contract
- This information may also be collected, used or released 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 is not 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 also have the right to request inspection and/or amendment of records retained by us that contain your PPI. Please contact Customer Service and ask that a request form be mailed 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 provided 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, uninsured motorist, or any other insurance under which you are or may be entitled to recover compensation
- The name of any other group insurance plan(s) under which you are covered

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

All rights to the benefits of this contract are available only to you. They may not be transferred or assigned to anyone else. We will not honor any attempted assignment, garnishment, or attachment of any right of this contract.

At our option and in accordance with the federal and state law, we may pay the benefits of this contract to the subscriber, 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.

Severability

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

Venue

All lawsuits, and legal proceedings, including arbitration proceedings, brought against us by you or anyone claiming any right under this plan must be filed:

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

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

Women's Health and Cancer Rights Act of 1998

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

Additional Information about Your Coverage

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

You may also ask for the following information:

- Your right to seek and pay for care outside of your plan and Premera is not responsible for any services provided outside your plan.
- The plan's drug list, also called a “formulary”
- How we pay providers
- How providers' payment methods help promote good patient care
- A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations
- How to file a complaint and a copy of our process for resolving complaints

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

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

Out-of-Area Care for Emergency Services

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 Washington and Alaska and in Clark County, Washington. 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.

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

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

BlueCard Program

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

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

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

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

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

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 Washington and Alaska and in Clark County, Washington that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. Please see the definition of ***Allowed Amount*** in ***Important Plan Information*** in this booklet for details on allowed amounts.

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

Blue Cross Blue Shield Global® Core

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the “Blue Cross Blue Shield Global® Core 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 Blue Cross Blue Shield Global® Core service area in

some ways. For instance, although Blue Cross Blue Shield Global® Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***How Do I File A Claim*** for more information. However, if you need hospital inpatient care, the Blue Cross Blue Shield Global® Core 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 Washington, Alaska and Clark County, Washington, need help submitting claims or have other questions, please call the Blue Cross Blue Shield Global® Core Service Center at 1-800-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.

More Questions

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

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
- A decision related to compliance with protections against balance billing as defined by federal and state law

Affordable Care Act

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

Ambulatory Surgical 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.

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 one of the following:

- An institutional review board that complies with 45 CFR Part 46
- The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
- The 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.

Congenital Anomaly

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

Contract

Contract describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan.

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.

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. and A.R.N.P.) 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 member, in serious jeopardy
- Result in serious impairment to bodily functions
- With respect to a pregnant member 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 member or the unborn child

Emergency Services

- Services and supplies including ancillary services given in an emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health.
- Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery.
- Ambulance transport as needed in support of the services above.

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, and assessments.

Facility (Medical Facility)

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

Health Care Benefit Managers

Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.

Home Medical Equipment (HME)

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

Home Health Agency

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

Hospice

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

Hospital

A healthcare facility that meets all of these criteria:

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

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

- As a rest home, nursing home, or convalescent home
- As a residential treatment center or health resort
- To provide hospice care for terminally ill patients
- To care for the elderly
- To treat substance use disorder 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.

Long-term Care Facility

A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.025, 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 that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the health of the member or their 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 substance use disorder.

Mental Health Services

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

Non-Participating Provider

A provider that is not in one of the provider networks stated in the ***How Providers Affect Your Costs*** section or does not have a contract with us.

Off-Label Prescription Drugs

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

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 this contract.

Prescription Drug

Drugs and medications that by law require a prescription. 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.)
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

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

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

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

This plan makes use of provider networks as explained in ***How Providers Affect Your Costs***.

Reconstructive Surgery

Reconstructive Surgery is surgery:

- Which 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 or 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

The service area is the geographic area in Washington state in which an individual must live in order to be eligible for this health plan. The service area for this plan are the following counties:

Franklin, Grays Harbor, King, Kitsap, and Pacific

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 disorder 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 disorder includes drug psychoses and drug dependence syndromes

State and federal law require that the copay and coinsurance for medically necessary outpatient and inpatient services provided 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.

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused.

Originating site: Hospital, Rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center

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.

Washington Health Benefit Exchange ("The Exchange")

The state authorized entity which determines eligibility to enroll in this plan.

We, Us and Our

Premera Blue Cross.

You and Your

A member enrolled in this plan.

CONTACT INFORMATION

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Toll Free.. 1-800-607-0546

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MAILING ADDRESS AND CLAIMS SUBMISSION

Medical Claims:

Premera Blue Cross
PO Box 21702
Eagan, MN 55121

Prescription Drug Claims:

Express Scripts
P.O. Box 14711
Lexington, KY 40512-4711

COMPLAINTS AND APPEALS

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