Premera Blue Cross Cascade Silver

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

Benefit Booklet for Individual and Families
Residing in Washington

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

49831WA1940006 (01-2026)

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Premera Blue Cross

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 premium, 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 and 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.

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 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 premiums.

If any provision of this Plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.

Translation Services

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

INTRODUCTION

Welcome

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

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.

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

What your health plan can help you do

Know your plan



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

Find care



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

Get care



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

Be well



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

Contact Information

Where To Send Claims

MAIL YOUR CLAIMS TO

Premera Blue Cross
PO Box 21702
Eagan, MN 55121

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
PO Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Administrator At

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

Customer Service

Mailing Address
Premera Blue Cross
PO Box 21702
Eagan, MN 55121

Physical Address
7001 220th St. SW
Mountlake Terrace, WA 98043

Phone Numbers
Local and toll-free number:
800-607-0546
Fax 866-903-9899

Local and toll-free TTY number for the deaf and hard-of-hearing:
711

Care Management

Prior Authorization
Premera Blue Cross
PO Box 21702
Eagan, MN 55121

Local and toll-free number:
844-996-0329
Fax 888-302-9325

Complaints and Appeals

Premera Blue Cross
Attn: Appeals Coordinator
PO Box 21702
Eagan, MN 55121

Local and toll-free number:
800-607-0546
Fax 866-903-9899

BlueCard

800-810-BLUE(2583)

Website

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

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Quick Care Guide

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

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

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

In-Network (Contracted)	Specific providers, hospitals, or labs that Premera contracts with to provide healthcare services to members. You typically pay less when using in-network healthcare providers. Your bills will be reimbursed at a higher percentage. In-network providers will not charge you more than the allowed amount.
Out-of-Network (Non-Contracted)	Services from healthcare providers and hospitals that have not contracted with Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee. This could mean the service will cost more or not be paid for at all by Premera. Your bills will be reimbursed at a lower percentage and you may also be required to submit the claim yourself.
Out-of-Pocket Maximum	The out-of-pocket maximum is the most you pay for covered services in a year before Premera pays 100% of the allowed amount. The out-of-pocket maximum includes an Individual and a Family Out-of-Pocket Maximum. However, if you get out-of-network care, you are still responsible for any charges above the allowed amount, except as prohibited by state or federal law. Expenses that do not apply toward the out-of-pocket maximum include, but not limited to: • Charges above the allowed amount • Services above any benefit maximum limit or durational limit • Services not covered by this plan • Services from out-of-network providers, except as prohibited by state or federal law • Covered services that do not apply to the out-of-pocket maximum as stated in ***Covered Services*** • If you participate in a health savings account (HSA) – Drug manufacturer coupons and other forms of cost-share assistance, per Internal Revenue Service requirements
Prior Authorization	Some services must be authorized in writing before you get them, in order to be eligible for coverage. The conditions, time limits and maximum limits are described in this booklet.
Visit, day, or hour limits	Some covered services have a maximum number of visits, days, or hours. After you reach this limit, you pay 100% out-of-pocket, whether or not you've met your deductible.
Year	The consecutive 12-month period that starts on your health plan's effective date. For this plan, it's a calendar year.

Overview

This plan is an Exclusive Provider Organization (EPO). This means that the plan is designed to only cover care delivered by providers in your plan's network. Your plan provides you benefits for covered services from providers within the Individual Signature network. You do not need a referral for specialty care. You may self-refer to in-network providers, including obstetricians, gynecologists, and pediatricians.

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

This plan makes available to you a sufficient number and types of providers to give you access to all covered services in compliance with applicable Washington state regulations governing access to providers. Our provider network includes hospitals, physicians, and a variety of other types of providers. See ***How Providers Affect Your Costs*** for more information.

Copay

	In-Network Providers	**Out-of-Network Providers**
Primary Care Provider copay	First 2 primary care, acupuncture, chiropractic adjustments, or hearing exam visits $1 copay, then $20 copay, deductible waived	*Not covered
Specialist copay	$65 copay, deductible waived	*Not covered

Coinsurance

	In-Network Providers	**Out-of-Network Providers**
	30%	*Not covered

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

Deductible

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

Out-of-Pocket-Maximum

	In-Network Providers	Out-of-Network Providers
Individual out-of-pocket maximum	$9,750	Not applicable
Family out-of-pocket maximum	$19,500	Not applicable

How Cost Shares Work

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

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



Office visit charges
$120



Allowed amount
$100



Your coinsurance
$20
(20% of the allowed amount)



Premera pays
$80
(80% of the allowed amount)



Your total responsibility
$20

Getting Care

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

- The provider's office can often look up your insurance and see that you're eligible.
- Download the Premera mobile app to get a digital ID card.

  iPhone and Android users can get the app from the Apple or Google Play App Store
- Call Premera customer service for your ID number.

Discover your care choices

You can see or call	When you need	What to do
Primary and specialty care providers	Routine and specialty care	Log in to premera.com and click "Find Care". You can search by name, type, or location.
Virtual care	A visit with a provider, counselor, or psychiatrist without going to an office. Have your appointment by computer, tablet, or mobile device wherever you are.	Set up your account at www.premera.com/visitor/virtual-care, then connect any day, any time, including weekends and holidays. Call customer service for assistance**.**
Urgent Care/Walk-in clinic	Same-day care for medical issues that need urgent attention but are not life threatening. Examples include, rashes, flu, minor burns or cuts, x-rays, and lab tests.	Log in to premera.com and click "Find Care". Choose "Urgent Care & Other Facilities" to search for locations closest to you.
Emergency services	Life-threatening emergency services	**Call 911** or go to an emergency room.
24-Hour NurseLine	Advice from a registered nurse for illnesses like fevers, the flu, and minor injuries.	Call **800-784-9265** (open 24 hours a day, seven days a week).

Important Plan Information

Primary Care Office Visits

You pay a lower office visit cost share for primary care office visits by selecting a PCP any time prior to an office visit. A list of network providers including PCPs and specialists is available by contacting customer experience or accessing the Premera website. Your PCP must be in the network and be one of the following provider types:

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

You do not need a referral from your PCP to see a specialist.

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

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

Please call customer service for more information about selecting a PCP and to provide us with your selection. Urgent care, telehealth, preventive, and specialty visits are not included. All other covered services provided by your selected PCP during the primary care office visit are subject to standard cost shares. For example, if you select a PCP and see that PCP for a cut that needs stitches, you will pay the 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.

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.

Out-of-Network

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

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

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

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

Non-Emergency Services Protected From Balance Billing

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

Emergency Services

The allowed amount for 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.

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

Ground or Air Ambulance

The allowed amount for non-participating ground or air ambulance providers will be calculated consistent with the requirements of federal or Washington state 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***, 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 only cover care delivered by providers in your plan's network. Your plan provides you benefits for covered services from providers within the Individual Signature network. You do not need a referral for specialty care. You may self-refer to in-network providers, including obstetricians, gynecologists and pediatricians.

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.

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

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

Individual Signature provider network directories are available any time on our website. You may also request a copy of this directory by calling customer service at the number located in ***Contact Information*** or on your Premera ID card.

In-Network Providers

In-network providers are networks of hospitals, physicians and other providers that are part of our Individual Signature network in Washington or that are part of the local Blue Cross Blue Shield licensee. These providers provide medical services at a negotiated fee. This fee is the allowed amount for in-network providers.

You do not need a referral from your PCP to see an in-network provider.

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.

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 in one of the networks (out-of-network) or (2) providers that do not have a contract with us (non-contracted). Except as stated ***in Benefits For Out-of-Network or Non-Contracted Providers***, or in a few specific benefits, services from these providers are not covered.

- **Out-of-network providers**. Some providers in Washington have a contract with us but are not in the Individual Signature network. In cases where this plan covers services from these providers, they will not bill you for the amount above the allowed amount for a covered service. The same is true for a provider that is in a different network of the local Host Blue plan.
- **Non-contracted providers**. There are also providers who do not have a contract with us. These providers are called "non-contracted" providers in this booklet.

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:

- Emergency services for a medical emergency. See ***Definitions*** 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.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received from a hospital that has a provider contract with 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.

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 include 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.

Ground Ambulance Services from a non-participating ground ambulance service organization for covered ground ambulance 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 more information, refer to www.insurance.wa.gov/sites/default/files/2025-02/consumer-notice-surprise-billing.pdf.

For the above services, you will pay no more than the plan's in-network cost-shares. 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.

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

Care Management

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

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call customer service 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 at In-Network Cost Shares** You or your in-network provider must get prior authorization in order for an out-of-network provider to be covered at the plan's in-network benefit level, except for emergency services. See ***Exceptions To Prior Authorization For Out-of-Network Providers*** below for more information.

How Prior Authorization Works

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

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

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

1. **Prior Authorization for Benefit Coverage**

   Medical Services, Supplies or Equipment

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

   - **In-network providers or facilities** are required to request prior authorization for the service.
   - **Out-of-network providers and facilities 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 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 ***Covered Services*** will apply. In-Network pharmacies will find out if an emergency fill is covered for your drug. The authorized amount of the emergency fill will be no more than the prescribed amount, up to a seven-day supply or the minimum packaging size available at the time the emergency fill is dispensed. See the process for emergency fills on our website at premera.com.

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
- For certain drugs, you may need to get a prescription from an appropriate medical specialist.
- 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.
- Services provided under involuntary commitment statutes are covered.
- Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth.

Emergency 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, non-emergent care provided by out-of-network providers is covered at a lower benefit level. However, you or your in-network provider may ask for a prior authorization to cover the out-of-network provider at the in-network benefit level if the services are medically necessary and only available from an out-of-network provider. You or your in-network provider must ask for prior authorization before you receive the services. You will need to reach out to your in-network provider to have them submit the appropriate forms. You may also initiate the process yourself by calling the toll-free customer support number on the back of your ID card.

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 at the in-network benefit level. 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. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.

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

CLINICAL REVIEW

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

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

You can find our medical policies at 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 provider to ensure appropriate and cost-effective medical care, to consider effective alternatives to hospitalization, or to support both of you in managing chronic conditions.

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

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

this policy remains in effect and

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

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

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

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

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

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

Continuity of care does not apply if your provider:

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

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

LEVELS OF CARE

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

Acute Inpatient Level of Care

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

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

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

Intermediate Level Facilities

- Long-term Acute Care Hospitals (LTAC or LTACH)
- Inpatient Rehabilitation Hospitals or Units

- Skilled Nursing Facilities (see ***Definitions*** for Skilled Nursing Facility and Skilled Nursing Care)
- Residential Treatment Programs in residential treatment facilities or wilderness settings

Intermediate care facilities are a bridge between acute and outpatient care settings. They serve those who do not require the intensity of service that acute hospitals provide, but are not yet ready to step-down to outpatient care. Their purpose is to improve function and stabilize you for transition to outpatient services. Intermediate level facilities provide care for patients' medical needs as well as daily living support. Patients typically reside in the facility for the duration of their treatment.

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

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

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

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

Intermediate Level Ambulatory or Outpatient Care

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

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

Outpatient Care

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

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

Covered Services

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

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

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

Related Benefit Information

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

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

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

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

Acupuncture

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Office and clinic visits	No limit	First 2 primary care, acupuncture, chiropractic adjustments, or hearing exam visits $1 copay, then $20 copay, deductible waived	Not covered
Other outpatient professional care	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

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

Allergy Testing and Treatment

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Testing and treatment	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

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

Ambulance

Medical transportation, usually for emergencies.

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Ambulance	No limit	$375 copay, deductible waived	$375 copay, in-network deductible waived

Benefit Overview

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

Additional Information

Ground ambulance services means:

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

Artificial Insemination

This benefit covers in vivo fertilization, a form of artificial insemination which facilitates the fusion of sperm and egg within the body.

Important things to know:
- Assisted reproduction methods, other than in vivo fertilization, are not covered.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Evaluation and diagnosis for infertility	No limit	Covered as any other service	Not covered
In vivo fertilization	No limit	Covered as any other service	Not covered

Benefit Overview

What services are included?	• Preliminary infertility evaluation and diagnosis • Placement of sperm into the cervix or uterus to achieve a pregnancy • Simple sperm preparation, such as sperm washing and isolation
What is excluded? (Premera pays 0%)	• All services and supplies (other than in vivo fertilization) related to conception by artificial means. • Prescription drugs related to such services • Donor semen and donor eggs used for such services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfers. • Donor sperm or eggs, or services related to procuring or storing these materials
Related benefit information	• For surgical procedures performed in a provider's office, surgical suite or other facility, see ***Surgery***. • Lab tests or images may be billed separately, see ***Diagnostic X-ray, Lab, and Imaging***. • Office visits are covered under ***Professional Visits and Services***.

At-Home Care

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

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

Home health care

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

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

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

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Home visits	130 visits / year	$30 copay per day, deductible waived	Not covered

Benefit Overview

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

What is excluded? (Premera pays 0%)	• Over-the-counter drugs, solutions, nutritional supplements • Non-medical services, like housekeeping • Services that bring you food or advice about food • The independent hiring of a nurse by a family or member to provide care without oversight by a home health agency
Related benefit information	• See ***Home Medical Equipment (HME) Orthotics, Prosthetics and Supplies*** for additional benefit information.

Skilled hourly nursing

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

Important things to know:

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

Examples of skilled hourly nursing services include:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Skilled hourly nursing	No limit	$30 copay per day, deductible waived	Not covered

Benefit Overview

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

Blood Products and Services

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Blood products and services	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

What services are included?	• Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.

Chemotherapy and Radiation Therapy

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

Important things to know:

- Chemotherapy and radiation must be prescribed by a provider and approved by Premera to be covered. See ***Prior Authorization***.
- If you are prescribed oral chemotherapy, it is covered under ***Prescription Drugs***.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Facility charges	No limit	Deductible, then 30% coinsurance	Not covered
Professional services	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

What services are included?	• Outpatient chemotherapy and radiation therapy • Supplies, solutions, and drugs used during a chemotherapy or radiation visit • Tooth extractions to prepare your jaw for radiation therapy
Related benefit information	• See ***Prior Authorization*** for more information on getting prior approval for services. • See ***Prescription Drugs*** for information on oral chemotherapy.

Chiropractic Adjustments

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Adjustments	10 visits / year	First 2 primary care, acupuncture, chiropractic adjustments, or hearing exam visits $1 copay, then $20 copay, deductible waived	Not covered

Benefit Overview

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

Clinical Trials

Qualified clinical trials are scientific studies that test and improve treatments of cancer and other life-threatening conditions.

Important things to know:

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

Cost Overview

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

Benefit Overview

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

Additional Information

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

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

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

Dental Injury and Facility Anesthesia

This section will go over two types of dental care:

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

Dental Injuries

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

Important things to know:

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

Cost Overview

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

Benefit Overview

What services are included?	**Dental Injury** • Exams • Consultations • Treatment of dental injuries to teeth, gum, and jaw • Oral surgery
What is excluded? (Premera pays 0%)	• Routine dental care, including the professional charges of the dentist or services received in the dental office • Injuries from biting or chewing, including injuries from a foreign object in food • Oral surgery treating any fracture of the mandible (jaw)
Related benefit information	• You may have additional costs for other services such as x-rays, labs, and hospital facility charges. See those covered services for details.

	• Facility charges are covered under ***Hospital.*** • See ***Prescription Drugs***. • Lab and diagnostic tests are covered under ***Diagnostic X-ray, Lab, and Imaging.*** • If surgery is needed due to injuries that involve dental or oral conditions, treatments would be covered under ***Surgery***.

Anesthesia for Routine Dental Care

Anesthesia for routine dental care is covered for any one of the following reasons when medically necessary:

- 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.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Anesthesiologist	No limit	Deductible, then 30% coinsurance	Not covered
Outpatient surgery center	No limit	Deductible, then $600 copay	Not covered
Inpatient facility care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Inpatient professional care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

What services are included?	**Dental Anesthesia** • Hospital or other facility care • General anesthesia provided by an anesthesia professional other than the dentist or the physician performing the dental care
What is excluded? (Premera pays 0%)	• Routine dental care, including the professional charges of the dentist or services received in the dental office
Related benefit information	• Tooth extractions related to radiation treatment are covered under ***Chemotherapy and Radiation Therapy***. • Services related to TMJ are covered under ***Temporomandibular Joint Disorders Care*** (TMJ).

Diagnostic X-ray, Lab, and Imaging

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Preventive care screening/tests	No limit	No charge	Not covered
Basic diagnostic x-ray and imaging	No limit	$65 copay, deductible waived	Not covered
Basic diagnostic lab and professional services	No limit	$40 copay, deductible waived	Not covered
Major	No limit	Deductible, then 30% coinsurance	Not covered
Diagnostic and supplemental breast exams	No limit	No charge	Not covered

Benefit Overview

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

What is excluded? (Premera pays 0%)	• Treatment of infertility, including but not limited to surgery (other than in vivo fertilization, see ***Artificial Insemination***), fertility drugs, and other medications associated with fertility treatment.

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

Additional Information

Diagnostic breast examination for the purpose of this ***Diagnostic X-ray, Lab, and Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast magnetic resonance imaging, breast ultrasound, or pathology evaluations (including biopsies and consultations), or other services based on guidelines established by government agencies and professional medical societies that is used to evaluate an abnormality:

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

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

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

Dialysis

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

Important things to know:

- In the case of dialysis, we recommend calling customer service to find in-network providers.
- If you have end-stage renal disease (ESRD), you may be eligible for Medicare. We recommend that you enroll in Medicare as soon as possible if you are eligible. This will reduce your costs substantially.
- When covered dialysis services are provided by an out-of-network provider in a county in Washington state where no in-network providers are available, the in-network cost shares will apply.
- Medicare has a waiting period, generally the first 90 days after dialysis starts. Medicare doesn't start covering any of your costs until after that waiting period.

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Dialysis	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

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

Emergency Services

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

Important things to know about emergency services:

- A typical emergency room visit results in multiple charges for things like the facility, professional services, and tests used to diagnose your condition. You may receive separate bills for each charge.
- Once you're stabilized, you will incur out-of-network charges if you choose to stay in an out-of-network facility.
- The copay is waived if you are admitted as an inpatient through the emergency room. The copay is waived if you are transferred and admitted to a different hospital directly from the emergency room.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Facility charges (ER copay waived if admitted)	No limit	Deductible, then $800 copay	In-network deductible, then $800 copay
Professional services	No limit	Deductible, then $800 copay	In-network deductible, then $800 copay

Benefit Overview

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

Foot Care

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

Examples of medical conditions include:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
In an office or clinic	No limit	See Professional Visits and Services	Not covered
All other professional settings	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

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

Gender Affirming Care

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

Important things to know:

- Benefits are provided for gender affirming surgical services which meet the requirements of Premera's medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from customer service, or at www.premera.com/visitor/medical-policies.
- For more information, visit www.premera.com/visitor/care-essentials/lgbt-health.
- If you can't find an in-network provider, or need information about what services are covered under your plan, call customer service.
- Gender affirming surgery results in multiple charges for things like the facility and professional services. You may receive separate bills for each charge.

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	See Professional Visits and Services	Not covered
Inpatient professional services	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Inpatient facility care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

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

Hearing Care

Hearing care benefits include hearing exams and hearing hardware.

Hearing Exam

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Hearing exam	One per calendar year	First 2 primary care, acupuncture, chiropractic adjustments, or hearing exam visits $1 copay, then $20 copay, deductible waived	First 2 primary care, acupuncture, chiropractic adjustments, or hearing exam visits $1 copay, then $20 copay, in-network deductible waived

Benefit Overview

What services are included?	• Examinations of the inner and exterior of the ear • Observation and evaluation of hearing, such as whispered voice and tuning fork • Case history and recommendations • Hearing testing services including the use of calibrated equipment • If hearing tests are done in a separate visit, any office visit copay does not apply to the testing.
What is excluded? (Premera pays 0%)	• Hearing hardware • Fitting examinations for hearing hardware. See ***Hearing Hardware***.

Hearing Hardware

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Hearing hardware	One hearing aid per ear with hearing loss every 3 years	30% coinsurance, deductible waived	30% coinsurance, in-network deductible waived

Benefit Overview

What services are included?	• To receive your hearing hardware benefit, you must:
	  ○ Be examined by a licensed provider before obtaining hearing aids.
	  ○ Purchase a hearing aid device.
	• Hearing aids (monaural or binaural) prescribed as a result of an exam
	• Ear molds
	• Fitting examinations for hearing hardware
	• The hearing aid instruments, including bone conduction hearing devices and the initial assessment, adjustment and auditory training

	• Hearing aid rental while the primary unit is being repaired • The initial batteries, cords and other necessary ancillary equipment • A warranty, when provided by the manufacturer • A follow-up consultation within 30 days following delivery of the hearing aids with the prescribing licensed provider • Repairs, servicing, and alteration of hearing aid equipment purchased under this benefit
What is excluded? (Premera pays 0%)	• Hearing aids purchased before your effective date of coverage under this plan • Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids • Hearing aids that exceed the specifications prescribed for correction of hearing loss. • Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended. • Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

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

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

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

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Home medical equipment, orthotics, prosthetics, and supplies	No limit	Deductible, then 30% coinsurance	Not covered
Foot orthotics and therapeutic shoes	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

What services are included?	**External Prosthetics and Orthotic Devices:** To replace, correct, or straighten a body limb. **Home Medical Equipment and supplies (fitting costs and sales tax) such as:** • Wheelchairs • Hospital beds • Traction equipment • Crutches • Ventilators • Insulin pump / blood glucose monitor and supplies **Orthopedic Shoes and Shoe Inserts:** For the treatment of complications from diabetes or other medical disorders that cause foot problems. **Medical Vision Hardware:** For members age 19 and older to correct vision due to medical eye conditions such as: • Corneal ulcer, abrasion, or recurrent erosion • Bullous keratopathy • Tear film insufficiency

	• Aphakia • Sjogren's disease • Congenital cataract • Keratoconus • Progressive high (degenerative) myopia • Irregular astigmatism • Aniridia • Aniseikonia • Anisometropia • Pathological Myopia • Post traumatic disorders
What is excluded? (Premera pays 0%)	• Supplies or equipment not primarily intended for medical use • Special or extra-cost convenience features • Items such as exercise equipment and weights • Physical changes to your house or personal vehicle (like elevators) • Over-bed tables, vision aids, and telephone alert systems • Non-wearable defibrillators, trusses, and ultrasonic nebulizers • Over-the-counter orthotic braces and/or cranial banding • Blood pressure cuffs/monitors (even if prescribed by a physician) • Bed-wetting (enuresis) alarm • Compression stockings which do not require a prescription • Orthopedic shoes used for sport, recreation, or similar activity • Penile prostheses • Hair prostheses, such as wigs or hair weaves, transplants and implants
Related benefit information	• See ***Pediatric Vision Care*** for routine eye exams, eyeglasses and contact lenses, and medical vision hardware for members under age 19. • See ***Rehabilitation Therapy*** for additional benefit information. • See ***Prescription Drugs*** for some diabetic testing supplies which can be purchased in a pharmacy. • See ***Surgery*** for prosthetics, intraocular lenses, equipment, or devices which require surgery. • Breast pumps are covered under ***Preventive Care***. • Not all equipment or supplies are covered. Some items need prior authorization from us. See ***Prior Authorization*** for details.

Hospice Care

A facility or program that provides palliative and supportive care, usually for terminally ill members.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Home visits	No limit	$30 copay per day, deductible waived	Not covered
Outpatient respite care	14 days / lifetime	Deductible, then 30% coinsurance	Not covered
Inpatient respite care	14 days / lifetime	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

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

Whose services are covered?	When provided by a hospice that is Medicare-certified or is licensed or certified by the state it operates in, the following are covered: • A registered nurse • A licensed practical nurse • A licensed physical or occupational therapist • A certified respiratory therapist • A certified speech therapist • A home health aide directly supervised by one of the above listed providers • A licensed social worker
What is excluded? (Premera pays 0%)	• Over-the-counter drugs, solutions, and nutritional supplements • Services provided to someone other than the ill or injured member • Services of family members or volunteers • Services, supplies or providers not in the written plan of care or not named as covered in this benefit • Non-medical services, such as spiritual, bereavement, legal or financial counseling • Normal living expenses, such as food, clothing, and household supplies; housekeeping services

Hospital

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

Important things to know:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Inpatient professional care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Inpatient facility charges	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Outpatient professional care	No limit	Deductible, then 30% coinsurance	Not covered
Outpatient facility charges	No limit	Deductible, then $600 copay	Not covered

Benefit Overview

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

	○ The tests can't be done without the use of a hospital. ○ You have a medical condition that makes hospital care medically necessary.
Related benefit information	• You may need to pay charges over the allowed amount if you get care from an out-of-network provider. See ***How Providers Affect Your Costs*** for details. • Non-emergency inpatient hospitalizations require prior authorization. See ***Prior Authorization*** for details.

Additional Information

The following facilities are not considered hospitals if it operates mainly for any of the purposes below:

- Rest, nursing, or convalescent homes
- Residential treatment centers
- Health resorts
- Facilities that provide hospice care for terminally ill patients
- Homes for the care of the elderly
- Facilities to treat and rehabilitate patients with alcohol or drug addictions (substance use disorder)
- Facilities that treat patients with tuberculosis

Infusion Therapy

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

Examples of infusion include:
- Drug therapy
- Pain management
- Total or partial parenteral nutrition (TPN or PPN)

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Infusion therapy treatments	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

What services are included?	• Outpatient facility and professional services • Professional services provided in an office or home • Prescription drugs, supplies and solutions used during infusion therapy
What is excluded? (Premera pays 0%)	• Over-the-counter drugs and solutions • Over-the-counter nutritional supplements

Mastectomy and Breast Reconstruction

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Mastectomy and breast reconstruction	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

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

Maternity Care

Care during pregnancy and childbirth, and immediately after the baby is born. Routine pregnancy exams and tests are covered under ***Preventive Care***.

Important things to know:

- A typical birth results in multiple charges for things like the facility, professional services, and diagnostic tests for both you and your baby. You may receive separate bills for each charge.
  You must enroll your newborn or newly adopted child within 60 days of the date of birth or date of adoption. **This is not automatic.**
- Hospital stays for maternity care are:
  - No less than 48 hours for a vaginal delivery; or
  - No less than 96 hours following a cesarean section.
  - The attending provider will determine an appropriate discharge time in consultation with the member.
- Breast pumps, breastfeeding support, and screening for postpartum depressions are covered. Please call Premera customer service for a list of approved providers.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Outpatient professional care	No limit	No charge	Not covered
Inpatient professional care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Inpatient hospital, birthing centers, and short-stay hospitals	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Abortion	No limit	No charge	Not covered

Benefit Overview

What services are included?	• Routine prenatal visits • Diagnostic and screening procedures, and genetic counseling • Delivery of your baby, including home birth • Additional post-delivery care, when the attending provider decides it's necessary, and it's based on accepted medical practice • Abortion • Medically necessary donor human milk for inpatient use is covered at no charge
Whose services are	• Physician (MD or DO), or a physician's assistant

covered?	• Certified nurse midwife (CNM) • A licensed midwife • Advanced registered nurse practitioner (ARNP)

What services are excluded? (Premera pays 0%)	• Assisted reproduction technologies such as:
	  ○ Artificial insemination (other than in vivo fertilization, see ***Artificial Insemination***) or in vitro fertilization
	  ○ Services to make you more fertile or for multiple births
	  ○ Reversing sterilization surgery

Related benefit information	• Certain laboratory services and ultrasounds are billed separately. See ***Diagnostic X-ray, Lab, and Imaging***. • Hospital care may be billed separately. See ***Hospital***. • Depression screening for pregnant and postpartum members are covered as preventive care. See ***Preventive Care***. • Non-emergency inpatient hospitalizations require prior authorization. See ***Prior Authorization*** for details.

Medical Foods

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Medical foods	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

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

Medical Transportation

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
For Transplants	$5,000 limit per transplant	Deductible, then 0% coinsurance	In-network deductible, then 0% coinsurance

Benefit Overview

What services are included?	• Ferry transportation from the member's home • Mileage expenses for the member's personal vehicle • Lodging expenses at commercial establishments, including hotels and motels, between the home and medical facility where the service will be provided • Ground transportation, car rental, taxi fares, and parking fees for the member and a companion (when covered) between the hotel and medical facility where services will be provided **Air Transportation** • Air travel expenses between the member's home and medical facility where services will be provided • Unrestricted coach class • Flexible and fully refundable round-trip airfare from a licensed commercial carrier
What is excluded? (Premera pays 0%)	• Charges and fees for booking changes • Cancellation fees • First class airline fees • International travel • Lodging at any establishment that is not commercial • Meals • Personal care items • Pet care, except for service animals • Phone service and long-distance calls • Reimbursement for mileage rewards or frequent flier coupons • Reimbursement for travel before contacting Premera and receiving prior authorization • Travel for medical procedures not listed above • Travel in a mobile home, RV, or travel trailer

	• Travel to providers outside the network or that have not been designated by Premera to perform the services • Travel insurance
Related benefit information	• See ***Transplants*** for covered transplants. • See ***Ambulance*** for emergent and planned non-emergent transportation services.

Additional Information

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

Reimbursement of Travel Claims

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

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

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

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

Transplants

You must pay for all travel expenses upfront and submit a Claim Reimbursement Form.

Mental Health Care

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

Important things to know:

- You can get mental health care virtually or in-person.
- Prescribed medications are covered under ***Prescription Drugs***.
- Inpatient care is only covered as long as it's medically necessary.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Office and clinic visits	No limit	First 2 Mental Health or Substance Use Disorder visits $1 copay, then $20 copay, deductible waived	Not covered
Outpatient professional services	No limit	$30 copay, deductible waived	Not covered
Inpatient and residential facility care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Inpatient professional care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Outpatient facility care	No limit	$30 copay, deductible waived	Not covered

Benefit Overview

What services are covered?	• Inpatient care • Outpatient care (including virtual care) • Residential facility care • Individual or group therapy • Family therapy, including couples therapy • Laboratory and testing services • Take home drugs you get in a facility • Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders • Services provided in your home, when medically appropriate • Applied behavioral analysis (ABA) therapy. See ***Additional Information***.
Whose services are covered?	• A state licensed or approved facility, program, or agency that provides mental health services within the scope of their state licensure. • A state licensed or certified clinician that provides mental health services within the scope of their state licensure or certification. • Any other provider listed under “provider” in ***Definitions*** who is licensed or certified in the state where care is provided, and who is providing care within the scope of their license. • Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care. • See ***Additional Information*** for who can provide ABA services.

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

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

Additional Information

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

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

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

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

Neurodevelopmental (Habilitation) Therapy

A treatment option for patients with neurological problems. The treatment is a hands-on approach that must be medically necessary to restore and improve or maintain function to enhance patient ability. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental or habilitation therapy.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Outpatient care	25 visits / year	$40 copay, deductible waived	Not covered
Inpatient care	30 days / year	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

What services are included?	• Physical, speech, and occupational therapy assessments related to treatment • Outpatient care is covered when the member isn't confined in a hospital or other medical facility.
Whose services are covered?	• Inpatient facility services must be provided and billed by a hospital or rehabilitation facility that meets our clinical standards and will only be covered when services can't be done in a less intensive setting. • Outpatient services must be provided and billed by a hospital or rehabilitation facility that meets our clinical standards, physician, physical, occupational or speech therapist, chiropractor, or naturopath.
What is excluded? (Premera pays 0%)	• Gym or swim therapy • Custodial care • Recreational, vocational, or education therapies • Exercise or maintenance level programs • Social or cultural therapy • Treatment that isn't actively engaged in by the ill, injured, or impaired member
Related benefit information	• See ***Rehabilitation Therapy, Psychological and Neuropsychological Testing*** for details on when to apply that benefit. • See ***Mental Health Care*** for therapies provided for mental health conditions, such as autism. • If you are using ***Rehabilitation Therapy*** for the same treatment reason, this benefit can't be applied at the same time. Once the maximum has been met for either, no additional benefits are available. • You must get a prior authorization from us before you get inpatient treatment. See ***Prior Authorization*** for details.

Newborn Care

Care your baby gets during and immediately after birth.

Important things to know:

- Newborn care is not covered at 100%. See ***Cost Overview*** below.
- Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive maternity care benefits under this plan.
- To continue benefits beyond the 3-week period, see ***Eligibility and Enrollment*** and ***When Coverage Begins***.
- Your newborn on your health plan may need to meet their own deductible.
- A typical birth results in multiple charges for things like the facility, professional services, and tests used to diagnose your newborn's condition. You may receive separate bills for each charge.
- You must enroll your newborn or newly adopted child within 60 days of the date of birth or date of adoption. **This is not automatic.**

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Newborn care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

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

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.

Pediatric Vision

Coverage for routine eye exams and hardware for members under age 19.

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Comprehensive vision exam	One / year	No charge	No charge
Glasses	One pair of glasses / year	No charge	No charge
Contacts	One pair of contacts or 12-month supply of contacts per calendar year instead of glasses (lenses and frames)	No charge	No charge
Low vision evaluation	One comprehensive low vision evaluation and 4 follow-up visits in a 5 calendar year period	No charge	No charge
Low vision devices	One / year	No charge	No charge

Benefit Overview

What services are included?	• 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
What is excluded? (Premera pays 0%)	• This plan does not cover routine adult vision exams to test visual acuity and/or to prescribe any type of vision hardware for members age 19 and older. • Vision therapy, eye exercise, or any sort of training to correct muscular imbalance

	of the eye (orthoptics), and pleoptics, treatment or surgeries to improve the refractive character of the cornea or results of such treatments.

Prescription Drugs

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

Important things to know:

- This plan uses a formulary drug list. **Please refer to your ID card for your formulary drug list.**
- If your copay is higher than the cost of a drug, you will always pay the lower amount.
- Retail pharmacy coverage is available up to a 90-day supply for prescription drugs. The cost share will be calculated for each 30-day supply.
- You can find a list of covered drugs (formulary drug list) on premera.com. Certain drugs need prior approval, see ***Prior Authorization*** for more details.
- A covered drug you may be taking can change from preferred to non-preferred or become not covered. This can happen at any time throughout the year, if this does occur, we'll notify you in writing 60 days before the change happens.
- If you participate in a health savings account (HSA) – Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy this plan's deductible.
- Some preventive drugs have limits on how often you and/or who should get them. The limits are often based on your age or gender. After one of these limits is reached, these services are not covered in full and you may have to pay more out-of-pocket costs.

Cost Overview

What is covered?	What will I pay? In-network	Out-of-network
Retail Pharmacy		
Preferred generic drugs	$25 copay, deductible waived (per 30-day supply)	Not covered
Preferred brand name drugs	$75 copay, deductible waived (per 30-day supply)	Not covered
Non-preferred generic and non-preferred brand name drugs	Deductible, then $250 copay (per 30-day supply)	Not covered
Mail-Order Pharmacy		
Preferred generic drugs	$75 copay, deductible waived (per 90-day supply)	Not covered
Preferred brand	$225 copay, deductible waived (per 90-	Not covered

name drugs	day supply)	
Non-preferred generic and non-preferred brand name drugs	Deductible, then $750 copay (per 90-day supply)	Not covered
Specialty Pharmacy		
Specialty drugs (per prescription or refill)	Deductible, then $250 copay (30-day supply)	Not covered
Needles and syringes purchased with diabetic drugs	No charge	Not covered
Nicotine Habit-Breaking Drugs	No charge	Not covered
Drugs on the Affordable Care Act's preventive drug list	No charge	Not covered
Oral chemotherapy drugs	Deductible, then 30% coinsurance	In-network deductible, then 30% coinsurance
Contraceptives	No charge	Not covered

Benefit Overview

What services are included?	• FDA approved formulary drugs. Federal law requires a prescription for these drugs. They are known as "legend drugs". • Glucagon and allergy emergency kits • Inhalers, supplies and peak flow meters • Some drugs that treat complex or rare health conditions may only be available at specialty pharmacies. • Prescribed preventive drugs required by the Affordable Care Act • Compound medications that contain at least one covered prescription drug • Certain prescription and generic over-the-counter drugs to break a nicotine habit • Drugs associated with an emergency medical condition

	• Prescribed epinephrine autoinjectors for the treatment of allergic reaction. (Your cost shares for at least one covered epinephrine autoinjector product containing at least two autoinjectors will not exceed $35, not subject to the deductible. Cost shares for covered prescription epinephrine autoinjectors apply towards the deductible.) **Asthma Inhalers** • Prescribed asthma inhalers for the treatment of asthma. (Your cost shares for covered prescription asthma inhalers for at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination that is FDA approved for the treatment of asthma will not exceed $35 per 30-day supply of the drug, not subject to the deductible. Cost shares for covered prescription asthma inhalers apply towards the deductible.) **Diabetic Drugs and Supplies** • Prescribed drugs for shots that you give yourself, such as insulin. (Your cost shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug, not subject to the deductible. Cost shares for covered prescription insulin drugs apply towards the deductible.) • Needles, syringes, alcohol swabs, test strips, testing agents, and lancets **Oral Chemotherapy** • Drugs you take by mouth that can be used to kill cancer cells or slow their growth. This benefit only covers the drugs that you get from a pharmacy. **Human growth hormone** • Human growth hormone is covered only for medical conditions that affect growth. It is not covered when the cause of short stature is unknown. Human growth hormone is a specialty drug. **Contraceptives** • All FDA-approved prescription and over-the-counter oral contraceptive drugs, supplies, and devices, including emergency contraceptives that are required to be covered by state or federal law. You must buy over-the-counter supplies and devices at the pharmacy counter. • Can receive up to a 12-month supply for contraceptive drugs (may be dispensed at a provider's office)
What is excluded? (Premera pays 0%)	• Over-the-counter drugs and supplies that aren't listed above as covered, even if you have a prescription • Non-formulary drugs • Blood or blood derivatives • Drugs used to improve your looks, such as drugs to increase hair growth or alter the appearance of your skin. • Drugs for experimental or investigational use • Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and healthcare provider administered injectable medications • More refills than the number prescribed, or any refill dispensed more than one year after the prescriber's original order • Drugs for use while you're in a health care facility or provider's office • Replacement of lost or stolen medication • Drugs to treat sexual dysfunction • Drugs to manage your weight • Immunization agents and vaccines • Drugs for fertility treatment or assisted reproduction procedures
Related benefit information	• For shots or devices from your provider, see ***Preventive Care***. • For details on how to submit a pharmacy claim, see ***How Do I File a Claim***.

	• For coverage related to medical equipment and supplies, see ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies***. • For blood or blood derivatives coverage, see ***Blood Products and Services***. • See ***Infusion Therapy*** for solutions and drugs that you get through a shot, intravenous needle, catheter, or a feeding tube. • To learn more about what experimental or investigational means, see ***Definitions***. • Certain drugs need prior approval. See ***Prior Authorization***.

Getting Your Prescriptions Filled

Pharmacy	Supply Limit	What to do
In-network retail pharmacies	Up to 90 days at a time	Pay the amount you're responsible for at the pharmacy. The cost share will be calculated for each 30-day supply.
In-network specialty pharmacies	30 days	Pay the amount you're responsible for at the pharmacy. If the drug dosing frequency (how often the drug is taken) requires more than a 30-day supply, the cost share will be calculated for each 30-day supply.
In-network mail-order pharmacy	90 days at a time	Ask your provider to prescribe up to a 90-day supply. **Fill your prescription one of two ways:** • Download the "Home Delivery Order Form" on premera.com and send via mail. • Call Premera customer service. Allow 2 weeks for your prescription to be filled.

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

Additional Information

The U.S. Food and Drug Administration (FDA) approves prescription drugs for specific health conditions or symptoms. Some drugs are prescribed for uses other than those the FDA has approved. This is known as "off-label use".

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 from:

1) 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
2) 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).
3) The Federal Secretary of Health and Human Services

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

Formulary Drug List

This benefit uses a specific list of covered prescription drugs, sometimes referred to as a "formulary drug list". Our Pharmacy and Therapeutics Committee, which includes providers and pharmacists from the community,

frequently reviews current medical studies and pharmaceutical information. The Committee makes recommendations on which drugs are included on our formulary drug lists. The formulary drug lists are updated quarterly based on the Committee's recommendations.

The formulary drug list includes both generic and brand name drugs. Consult the List of Covered Drugs (formulary drug list) on our website or contact customer service for a complete list of your plan's covered prescription drugs.

Drugs not included in the formulary drug list (non-formulary drugs) are not covered by this plan.

Exceptions Request for Non-Formulary Drugs

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

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

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

Expedited Exceptions Request for Non-Formulary Drugs

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

External Review for Non-Formulary Drugs

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

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

Pharmacy Management

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

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

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

Dispensing Limits

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

Preventive Drugs

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

Using In-network Pharmacies

When you use an in-network pharmacy, always show your 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 ***Covered Services***.

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 ***Covered Services***.

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

To find our in-network specialty pharmacies, visit the pharmacy section of our website at premera.com or call customer service for more information. If you wish to fill your specialty drug at a non-specialty in-network pharmacy, please call customer service for more information.

Your Right to Safe and Effective Pharmacy Services

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

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 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

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

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

Certain formulary drugs are subject to prior authorization. As part of this review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent drug.

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

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

The formulary drug list is updated frequently throughout the year. See “Formulary Drug List” above. If changes are made to the formulary drug list that may negatively impact your cost share, you will receive a letter advising you of the change.

What should I do if I want a change from limitations, exclusions, substitutions, or cost increases for drugs specified in this plan?

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can't be changed. Provisions regarding substitution of some drugs are described above in question 1.

You can appeal any decision you disagree with. See ***Complaints and Appeals***, or call our customer service department at the telephone numbers listed in ***Contact Information*** for information on how to initiate an appeal.

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

The amount you pay for covered drugs dispensed by a retail pharmacy, mail-order pharmacy or specialty pharmacy is described in the ***Cost Overview***.

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.

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

What other pharmacy services does my health plan cover?

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

Preventive Care

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

Services are considered preventive when recommended or required by:

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

Visit healthcare.gov for more information.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Screening tests	No limit	No charge	Not covered
Colon cancer screening	No limit	No charge	Not covered
Wellness exams	No limit	No charge	Not covered
Contraceptives and tubal ligation	No limit	No charge	Not covered
Nutritional counseling and therapy	No limit	No charge	Not covered
Immunizations in the provider's office	No limit	No charge	Not covered

Seasonal immunizations at a pharmacy or mass immunizer location	No limit	No charge	No charge
Travel immunizations at a travel clinic or county health department	No limit	No charge	No charge
Health education and training (outpatient)	No limit	No charge	Not covered
Nicotine habit-breaking programs	No limit	No charge	Not covered

Benefit Overview

What services are included?	**Wellness exams**, including those for school, sports, and jobs. **Screening tests and imaging**, such as: • Mammograms (including 3-D) • Pap smears • Prostate-specific antigen tests • BRCA genetic tests for members at risk for certain breast cancers • Diabetes screening **Patient navigation services** are also available to ensure timely diagnosis, treatment and support for breast and cervical cancer screenings. These services include, but are not limited to: • Person centered assessment and planning • Healthcare access and health navigation system • Referrals to appropriate support services (language translation, transportation and social services) • Patient education • Navigation services include person-to-person contact. This can be in person, virtual or both **Colon cancer screening** (for high-risk individuals and all individuals 45 years of age or older): • Pre-colonoscopy consultation and exam • Barium enema • Colonoscopy, sigmoidoscopy, and fecal occult blood tests • If polyps are found during the screening, their removal and lab tests are covered as preventive. • Medically necessary anesthesia • Colonoscopies as follow-up to a positive non-invasive stool-based screening tests **Contraceptives and tubal ligation:**

	• Contraceptive devices, shots, and implants, including anesthesia. This plan will cover up to 12-month supply of contraceptive drugs (may be dispensed at a provider's office). • Plan B (emergency contraceptive) • Tubal ligation (other services, like anesthesia, are covered as preventive only if tubal ligation is the primary procedure) **Routine maternity care:** • Routine prenatal and postnatal exams and tests • Breastfeeding support and counseling • Standard breast pump (bought from approved suppliers) **Call Premera customer service for a list of approved suppliers**. • Rental of hospital-grade breast pump Outpatient **nutritional counseling and therapy** for obese adults and children, and members at risk for health conditions affected by diet. **Immunizations**, including seasonal and for travel. **Pre-exposure prophylaxis (PrEP)** for members at high-risk for HIV infection. **Post-exposure prophylaxis (PEP)** **Health education and training:** • Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma • The program or class must take place in an approved setting, like a hospital. **Nicotine habit-breaking programs**
What is excluded? (Premera pays 0%)	• Gym memberships/fees or exercise classes or programs • Exams for insurance or work-related disability purposes
Related benefit information	• For tests and services to evaluate a sign, symptom or health, see ***Diagnostic, X-ray, Lab, and Imaging.*** • See ***Prescription Drugs*** for take-home or over-the-counter items. • See ***Newborn Care*** for routine newborn exams when the child is in the hospital after birth. • If tubal ligation is a secondary procedure, it is still covered as preventive. However, related services like anesthesia are covered under the primary procedure. See ***Hospital*** and ***Surgery.*** • For vasectomy, see ***Surgery***.

Professional Visits and Services

Care by a qualified provider to examine, diagnose, or treat an illness or injury. This includes app-based care, which connects a member to qualified providers via a telemedicine application (app).

Important things to know:
You can get care:

- At a provider's office or other medical setting
- At home, when medically necessary
- Virtually (secure chat, text, voice or video)
  - Schedule a virtual visit with an office-based provider (you'll pay for an office visit), or
  - Use a Premera-designated app to get care. See ***Virtual Care***. **Call Premera for a list of covered apps.**

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Designated PCP office and clinic visits (including virtual care)	No limit	First 2 primary care, acupuncture, chiropractic adjustments, or hearing exam visits $1 copay, then $20 copay, deductible waived	Not covered
Office visits for women's health (e.g. gynecologist)	No limit	First 2 primary care, acupuncture, chiropractic adjustments, or hearing exam visits $1 copay, then $20 copay, deductible waived	Not covered
All other professional office and clinic visits (including specialists and non-specialists)	No limit	$65 copay, deductible waived	Not covered

Benefit Overview

What services are included?	• Care by a qualified provider to examine, diagnose, or treat illness or injury • Second opinions for any covered medical diagnosis or treatment plan
What is excluded? (Premera pays 0%)	• Hair analysis or non-prescription medicines, such as herbal, naturopathic or homeopathic medicines or devices • Services used to improve your appearance, such as services to increase hair growth or alter the appearance of your skin
Related benefit information	• For preventive services like wellness exams, see ***Preventive Care***. • For surgical procedures performed in a provider's office, surgical suite or other facility, see ***Surgery***.

	• For mental health conditions, see **Mental Health Care**. • For substance use disorder conditions, see ***Substance Use Disorder***. • Facilities may be billed separately, see ***Hospital***. • Lab tests or images may be billed separately, see ***Diagnostic X-ray, Lab, and Imaging***. • See ***Home Health Care*** and ***Hospice Care*** for care in those settings. • See ***Rehabilitation Therapy***.

Psychological and Neuropsychological Testing

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Psychological and Neuropsychological testing	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

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

Rehabilitation Therapy

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, or to treat disorders caused by a physical congenital anomaly.

Important things to know:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Outpatient care	25 visits / year	$40 copay, deductible waived	Not covered
Inpatient care	30 days / year	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

What services are included?	**Inpatient Care is covered when:** • It's medically necessary and you cannot get these services in a less intensive care setting. • Provided by a specialized inpatient rehab center (this could be part of a hospital) • The care is part of a written treatment plan prescribed by your provider. **Outpatient Care is covered for:** • Physical, speech, hearing, and occupational therapies, assessments, and evaluations related to rehab • Cochlear implants • Home medical equipment, medical supplies, and devices
Whose services are covered?	• Physical therapist • Occupational therapist • Speech language pathologist • Any other licensed provider practicing within the scope of their license
What is excluded? (Premera pays 0%)	• Treatment that the ill, injured, or impaired member does not actively take part in • Therapy for flat feet except to help you recover from surgery to correct flat feet
Related benefit information	• For services related to a mental health condition, see ***Mental Health Care***. • Chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases are covered as

	any other medical condition and do not accrue to rehabilitation therapy limits. • If you are using ***Neurodevelopmental (Habilitation) Therapy*** for the same treatment reason, this benefit can't be applied at the same time. Once the maximum has been met for either, no additional benefits are available.

Skilled Nursing Facility Care

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Skilled nursing facility care	60 days / year	Deductible, then $800 copay per day	Not covered
Long-term care facility	60 days / year	Deductible, then $800 copay per day	Not covered

Benefit Overview

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

Substance Use Disorder

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Office and clinic visits	No limit	First 2 Mental Health or Substance Use Disorder visits $1 copay, then $20 copay, deductible waived	Not covered
Outpatient professional services	No limit	$30 copay, deductible waived	Not covered
Inpatient care and residential facility care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Outpatient facility care	No limit	$30 copay, deductible waived	Not covered

Benefit Overview

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

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

Surgery

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Surgery	No limit	Deductible, then $200 copay	Not covered
Outpatient professional services	No limit	Deductible, then 30% coinsurance	Not covered
Outpatient surgical center facility	No limit	Deductible, then $600 copay	Not covered
Vasectomy	No limit	No charge	Not covered

Benefit Overview

What services are included?	• Surgical services, including injections, when performed on an inpatient or outpatient basis • Vasectomy • Anesthesia or sedation • Medically necessary postoperative care • Transfusion of blood or blood derivatives (storage is covered only when medically necessary) • Correction of functional disorders • Cochlear implants • Cornea transplantation, skin grafts, and repair of a dependent child's congenital anomaly • Medically necessary surgery to correct the cause of infertility. This doesn't include assisted reproduction techniques (other than in vivo fertilization, see ***Artificial Insemination***) or sterilization reversal. • Diagnostic colonoscopy and sigmoidoscopy services not covered under ***Preventive Care*** • Biopsies and scope insertion procedures such as endoscopies • Reconstructive surgery that is needed because of an injury, infection or other illness • Sexual reassignment surgery if medically necessary • Outpatient surgical center services and supplies
Whose services are covered?	• Hospital • Ambulatory surgical centers • Surgical suite • Provider's office • Services provided by a surgeon
What is excluded? (Premera pays 0%)	• Removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss • The use of an anesthesiologist for monitoring and administering general anesthesia for endoscopies, colonoscopies and sigmoidoscopies unless medically necessary when specific medical conditions and risk factors are present • Cosmetic surgery
Related benefit information	• See ***Mastectomy and Breast Reconstruction*** for those covered services. • For preventive colonoscopy benefits, see ***Preventive Care***. • For gender affirming surgery benefits, see ***Gender Affirming Care***. • For organ, bone marrow, or stem cell transplant procedure benefits, see ***Transplants.*** • See ***Hospital*** for your facility cost share amounts. • See ***Artificial Insemination*** for in vivo fertilization benefits.

Temporomandibular Joint Disorders Care (TMJ)

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

Important things to know:

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

Examples of symptoms linked with TMJ include:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	See Professional Visits and Services	Not covered
Inpatient facility care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered
Inpatient professional services	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered

Benefit Overview

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

Additional Information

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

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.

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

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

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

Therapeutic Injections

Minimally invasive treatment to help reduce swelling and relieve pain in an affected joint or muscle.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Therapeutic Injections	No limit	Deductible, then 30% coinsurance	Not covered

Benefit Overview

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

Transplants

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	See Professional Visits and Services	Not covered*
Inpatient facility care	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered*
Inpatient professional services	No limit	Deductible, then $800 copay per day, up to 5 days per admit	Not covered*

*All Approved Transplant Centers are covered at the in-network level of benefits

Benefit Overview

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

Additional Information

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

Urgent Care

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Freestanding urgent care centers	No limit	$65 copay, deductible waived	Not covered
Urgent care centers attached to, or part of a hospital	No limit	Deductible, then $800 copay	In-network deductible, then $800 copay

Benefit Overview

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

Virtual Care

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

Important things to know:
Services must meet the following requirements:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Virtual General Visit	No limit	See Professional Visits and Services	Not covered
Virtual Mental Health Visit	No limit	First 2 Mental Health or Substance Use Disorder visits $1 copay, then $20 copay, deductible waived	Not covered
Virtual Substance Use Disorder Visit	No limit	First 2 Mental Health or Substance Use Disorder visits $1 copay, then $20 copay, deductible waived	Not covered

Benefit Overview

What services are included?	• Chat • Text • Voice • Audio messaging and video chat

Exclusions and Limitations

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

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

Court-Ordered Services	Services that you must get to avoid being tried, sentenced, or losing the right to drive when they are not medically necessary.
Custodial Care	Custodial services that are not covered hospice care services.
Dental Care	Dental care or supplies, that are not covered under any dental benefits.
Environmental Therapy	Therapy designed to provide a changed or controlled environment.
Experimental or Investigational Services	Experimental or investigational services or supplies, including any complications or effects of such services. This does not apply to certain services that are part of an approved clinical trial.
Family Members or Volunteers	Services or supplies that you provide to yourself. It also doesn't cover a provider who is: • Your spouse, mother, father, child, brother, or sister • Your mother, father, child, brother, or sister by marriage • Your stepmother, stepfather, stepchild, stepbrother, or stepsister • Your grandmother, grandfather, grandchild, or their spouse • A volunteer
Governmental Facilities	Services provided by a state or federal facility that are not emergency services or required by law or regulation.
Hair Analysis	
Hair Loss	• Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth • Hair prostheses, such as wigs or hair weaves, transplants and implants
Illegal Acts, Illegal Services, and Terrorism	Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.
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, including any related civilian forces or units
Non-Covered Services	Services or supplies directly related to any non-covered condition. • Ordered when this plan is not in effect or when the person is not covered under this plan • Provided to someone other than the ill or injured member • That are not listed as covered under this plan • Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay • Non-treatment charges, including charges for provider time • Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. • Doing housework or chores for the member or helping the member do housework or chores
Non-Treatment Facilities, Institutions or Programs	• Institutional care • Housing • Incarceration

	• Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions Examples are prisons, nursing homes, and juvenile detention facilities
Orthodontia	Orthodontic services, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.
Orthognathic Surgery	Procedures to lengthen or shorten the jaw. Orthognathic surgery is not covered other than for treatment of the following: • temporomandibular joint disorder, • injury, • sleep apnea, or • congenital anomaly
Personal comfort or convenience items	• Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting • Normal living needs, such as food, clothes, housekeeping, and transport. This doesn't apply to chores done by a home health aide as prescribed in your treatment plan. • Dietary assistance, including “Meals on Wheels”
Provider’s Licensing or Certification	Services that are outside the scope of the provider’s license or certification or any unlicensed or uncertified providers.
Recreational, Camp and Activity Programs	Recreational, camp and activity-based programs. These programs are not medically necessary and include: • Gym, swim and other sports programs, camps, and training • Creative art, play and sensory movement and dance therapy • Recreational programs and camps • Boot camp programs, outward bound programs and tall-ship programs • Equine programs and other animal-assisted programs and camps • Exercise and maintenance-level programs • Hiking, and other adventure programs and camps
Serious Adverse Events and Never Events	Serious Adverse Events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge. Never Events are events that should never occur, such as a surgery on the wrong patient, surgery on the wrong body part or a wrong surgery. Members and this plan are not responsible for payment of services provided by providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. Providers may not bill members for these services and members are held harmless. Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.
Services or Supplies Not Medically Necessary	Services or supplies that are not medically necessary even if they are court ordered. This also includes places of service, such as inpatient hospital care or stays.
Sexual Dysfunction	Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical, or psychological treatment of impotence or hypoactive sexual desire disorder, including drugs, medications, or penile or other implants.

Vision Exams	Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware for members 19 and older.
Vision Hardware	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, light-sensitive lenses, or smart glasses (such as augmented reality glasses), 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 of these treatments.
Voluntary Support Groups	Patient support, consumer, or affinity groups such as diabetic support groups or Alcoholics Anonymous.
Weight Loss Surgery or Drugs	Surgery, drugs or supplements for weight loss or weight control.
Work-Related Illness or Injury	Any illness, condition, or injury for which you get benefits under: • Separate coverage for illness or injury on the job • Workers compensation laws • Any other law that would repay you for an illness or injury you get on the job

Other Coverage

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 HEALTH 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. See ***COB's Effect on Benefits*** for details on primary and secondary plans.

If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan 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 fail to submit your claim to your secondary health 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 health plan, you or your provider will need to submit your claim to the secondary health 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 and plans any changes in your coverage.

COB DEFINITIONS

For the purposes of COB:

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

	plans is not an allowable expense. The allowable expense for the secondary plan is the amount it allows for the service or supply in the absence of other coverage that is primary. This is true regardless of what method the secondary plan uses to set allowable expenses. The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.
Custodial Parent	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	Gatekeeper requirements are any requirements that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. Examples are restrictions of coverage to providers in a network, prior authorization, or primary care provider referrals.

PRIMARY AND SECONDARY RULES

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

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

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

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

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

	○ The plan covering the non-custodial parent, third ○ The plan covering the spouse of the non-custodial parent, last If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.
Retired or Laid-off Employee	The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.
TRICARE	If you are a member of the U.S. military (active or retired) or you have dependents enrolled in the TRICARE program, this plan is the primary plan and TRICARE would be secondary, when required by federal law.
Continuation Coverage	If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that is not through COBRA or other continuation law. **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***.

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

RIGHT OF RECOVERY/FACILITY OF PAYMENT

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

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

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

THIRD PARTY LIABILITY (SUBROGATION)

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

Definitions The following terms have specific meanings in this contract:

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

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

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

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

UNINSURED AND UNDERINSURRED 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?

Medical Claims

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

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

Step 2.
Collect required documents
	If requesting reimbursement for medical care, include:
	• Proof of payment (if applicable).
	• An itemized bill that includes:
	  ○ Name of the patient
	  ○ Date of service
	  ○ Name, address, and IRS tax ID of the provider
	  ○ Diagnosis code (ICD-10) – You can get this from your provider
	  ○ Procedure code (CPT-4, HCPCS, ADA, or B-04) – You can get this from your provider
	  ○ Itemized charge for each service received
	  ○ Member ID numbers for both subscriber and the group
	
	If you're also covered by another health insurance (including Medicare) and it's your primary, you must attach a copy of the explanation of benefits from the other health plan.

Step 3. **Send in my claim**	To help process your claim, the form must be fully completed, signed, and returned with all required documents. Send your documents one of two ways: • **Email through your Secure Inbox** Sign into your account at premera.com and select Secure Inbox. Scan and send the completed form and any required documents back to us as a secure email attachment. • **Mail to** Premera Blue Cross PO Box 21702 Eagan, MN 55121 **Note:** Any highlights or modifications to your bill may delay processing your claim.

Prescription Drug Claims

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

Timely Filing

We must receive claims:

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

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

Special Notice About Claims Procedure

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.

Additional Information

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

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

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

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.

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 your 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 800-607-0546 (TTY: 711)

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 decision. **OR** 180 days from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. Get the form	• Complete the Member Appeal Form, you can find it on premera.com or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeal process, call customer service.
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. 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 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 Attn: Appeals Coordinator 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

Attn: Appeals Coordinator
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 e-mail 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 the 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 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 Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 844-990-0262

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

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

Eligibility And Enrollment

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

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.

Subscriber	Individuals can only apply during an open enrollment or special enrollment period. See ***Open Enrollment*** and ***Special Enrollment***.

Dependents	To be a dependent under this plan, the family member must be:
	• 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.”
	• An eligible child who is under 26 years of age, except as provided for in ***Continued Eligibility for a Disabled Child***. An eligible child is one of the following:
	  ○ A natural offspring of either or both the subscriber or spouse
	  ○ A legally adopted child of either or both the subscriber or spouse
	  ○ A child placed with the subscriber for the purpose of legal adoption in accordance with state law. “Placed” for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
	  ○ A legally placed dependent or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
	  ○ A child for whom the subscriber or spouse is required by a medical child support order to provide health coverage.

OPEN ENROLLMENT

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

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. See 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 premiums 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, see ***Open Enrollment***.

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 premium 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 premiums. An enrollment application isn't required when premiums 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 ***Eligibility and Enrollment***.
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 ***Eligibility and Enrollment***.
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 premiums 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 ***Eligibility and Enrollment***.
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 ***Eligibility and Enrollment***.
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 ***Eligibility and Enrollment***.

OTHER PROVISIONS AFFECTING COVERAGE

Term of Contract	This contract is guaranteed renewable except as stated under ***Events That End Coverage***.
Premiums 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 premiums. Premiums are not accepted from third party payers including employers, providers, non-profit or government agencies, except as required by law.
Federal Government Assistance with Premiums	If the federal government is paying a portion of your premium as an advance payment of the premium tax credit, you have a different grace period to pay your portion of the premiums. 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 premiums. • 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 premiums 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 premiums that were due during the 12-month period prior to your re-application for coverage.
No Federal Government Assistance with Premiums	For members whose premiums are not subsidized by the federal government, you have a 1-month grace period to pay subsequent premiums. 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 premiums 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 premiums annually upon written notice (see ***Notice***). 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 premiums will constitute acceptance of the change. Premiums will also be revised in the following situations: • A change in the number of enrolled dependents, except when premiums 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, including a mandated change in benefits, eligibility or other plan provisions, or imposition or changes to an assessment or tax on our revenue. Premiums 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 of Coverage

EVENTS THAT END COVERAGE

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 premiums were paid.
- Failing to pay the required premiums 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 premiums. Coverage will end without notice as of the last date for which premiums 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 ***Eligibility and Enrollment.***
- 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 premiums received for dates beyond the contract termination date stated in our notice to you (see ***Notice***).

Continuation of Coverage

There are specific requirements, time frames and conditions which must be followed in order to be eligible for continuation of coverage and which are generally outlined below.

Continued Eligibility for a Disabled Child	Coverage may continue beyond the limiting age (see ***Dependent Eligibility***) for a child who cannot support themselves because of a developmental or physical disability. The child will continue to be eligible if all the following are met: • The child became disabled before reaching the limiting age. • The child is incapable of self-sustaining employment by reason of developmental or physical disability and is chiefly dependent upon the subscriber for support and maintenance. • The subscriber is covered under this plan. • The child's premiums, if any, continue to be paid. • Within 31 days of the child reaching the limiting age, the subscriber furnishes us

	with a Request for Certification of Disabled Dependent form. We must approve the request for certification for coverage to continue. • The subscriber provides us with proof of the child's disability and dependent status when we request it. We won't ask for proof more often than once a year after the 2-year period following the child's attainment of the limiting age.
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. Premiums 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 premiums 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 premiums 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

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

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

	• The contract • All applications used to apply for coverage • All attachments, endorsements, and riders included or issued hereafter No representative of Premera Blue Cross or any other entity is authorized to make any changes, additions or deletions to the contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done with the signature of an officer of Premera Blue Cross. If there is a language conflict in the contract, the benefit booklet (as amended by any attachments, endorsements or riders) will govern.
Evidence of Medical Necessity	We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you, or on your behalf by your healthcare providers. No benefits will be available if the proof isn't provided or acceptable to us.
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 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 they have 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. The Blue Cross and Blue Shield Association licenses Premera Blue Cross to offer certain products and services under the BLUE CROSS® brand name. Premera Blue Cross is an independent organization governed by its own Board of Directors, and responsible for its own obligations. A copy of Premera Blue Cross's most recent audited financial statement is available on request to Premera Blue Cross.
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 Statements	If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, we'll be entitled to recover these amounts. See ***Right of Recovery***. 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. **Note:** We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.
Limitations of Liability	We are not legally responsible for any of the following: • Epidemics, disasters, or other situations that prevent members from getting the care they need • The quality of services or supplies that members get from providers, or the amounts charged by providers • Providing any type of hospital, medical, dental, vision, or similar care • Harm that comes to a member while in a provider's care • Amounts in excess of the actual cost of services and supplies • Amounts in excess of this plan's maximums. This includes recovery under any claim of breach • General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages
Member Cooperation	You're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.
Newborn's and Mother's Health Protection Act	Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours).
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.
Notice	We may be required to send you certain notices. We will consider such a notice to be delivered if we mail or email it to your most recent mailing or email address in our records. The date of the postmark or email sent is the delivery date. If you are required to send notice to us, the postmark date will be the delivery date. If not postmarked, the delivery date will be the date we receive it.
Notice of Information Use and Disclosure	We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources. This information is collected, used or disclosed for conducting routine business operations such as:

	• Determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.) • Coordinating benefits with other healthcare plans • Conducting care management, case management, or quality reviews • Fulfilling other legal obligations that are specified under the contract This information may also be collected, used or disclosed as required or permitted by law. To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it. If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization. You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our customer service department and ask a representative to mail a request form to you.

Notice of Other Coverage	As a condition of receiving benefits under this plan, you must notify us of:
	• Any legal action or claim against another party for a condition or injury for which we provide benefits; and the name and address of that party's insurance carrier
	• The name and address of any insurance carrier that provides:
	  ○ Personal injury protection (PIP)
	  ○ Underinsured motorist coverage
	  ○ Uninsured motorist coverage
	  ○ Any other insurance under which you are or may be entitled to recover compensation
	• The name of any other group or individual insurance plans that cover you

Rights of Assignment	Notwithstanding any other provision in this contract, and subject to any limitations of state or federal law, in the event that we merge or consolidate with another corporation or entity, or do business with another entity under another name, or transfer this contract to another corporation or entity, this contract shall remain in full force and effect, and bind the subscriber and the successor corporation or other entity. We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.
Right of Recovery	We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us. In addition, if this contract is voided as described in ***Intentionally False or Misleading Statements***, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.
Right to and Payment of Benefits	Benefits of this plan are available only to members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan. At our option only and in accordance with the law, we may pay the benefits of this

	plan to: • The subscriber • A provider • Another health insurance carrier • The member • Another party legally entitled under federal or state medical child support laws • Jointly to any of the above Payment to any of the above satisfies our obligation as to payment of benefits.
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 suits or legal proceedings brought against us by you or anyone claiming any right under this plan must be filed: • Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable • In the state of Washington or the state where you reside or are employed All suits or legal or arbitration proceedings brought by us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in King County, the state of Washington.
Women's Health and Cancer Rights Act of 1998	Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. See ***Covered Services***.
Out-of-Area Care	As a member of the Blue Cross Blue Shield Association (“BCBSA”), Premera Blue Cross has arrangements with other Blue Cross and Blue Shield Licensees (“Host Blues”) for care outside our service area. These arrangements are called “Inter-Plan Arrangements”. Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue. The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' in-network providers. The Host blue is responsible for its in-network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (non-contracted providers). ***Out-Of-Area Care*** explains how the plan pays both types of providers. When you get services through these Inter-Plan Arrangements, it does not change what the plan covers, benefit levels, or any stated eligibility requirements. Please call us if your care needs a prior authorization. We process claims for the ***Prescription Drugs*** benefit directly, not through an Inter-Plan Arrangement.
BlueCard Program	Except for copays, we will base the amount you must pay for claims from Host Blues' in-network providers on the lower of: • The provider's billed charges for your covered services; or • The allowed amount that the Host Blue made available to us. Often, the “allowed amount” is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers. Host Blues may use a number of factors to set estimated or average prices. These

	may include settlements, incentive payments, and other credits or charges. Host Blues may also need to adjust their prices to correct their estimates of past prices. However, we will not apply any further adjustments to the price of a claim that has already been paid. **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 our service area that do not have a contract with the Host Blue. In most cases we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. See the definition of "allowed amount" in ***Important Plan Information*** of this booklet for details on allowed amounts. In these situations, you may owe the difference between the amount that the non-contracted provider bills and the payment the plan makes for the covered services as set forth above. **Blue Cross Blue Shield Global® Core** If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core. Blue Cross Blue Shield Global® Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global® Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***How Do I File A Claim*** for more information. However, if you need hospital inpatient care, the service Center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you. If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at 800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 804-673-1177. **More Questions** If you have questions or need to find out more about the BlueCard Program or Blue Cross Blue Shield Global® Core, please call our customer service department. You can find a provider on premera.com or by calling 800-810-BLUE (2583).
Additional Information About Your Coverage	Your benefit booklet provides you with detailed information about this plan's benefits, limitations and exclusions, how to obtain care and how to appeal our decisions. You may also ask for the following information: • Your right to seek and pay for care outside of this plan • The plan's formulary drug list • How we pay providers • How providers' payment methods help promote good patient care • A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations • How to file a complaint and a copy of our process for resolving complaints

	• How to access specialists • Obtaining a prior authorization when needed • Accreditation by national managed care organizations • Use of the health employer data information set (HEDIS) to track performance If you want to receive this information, please go to our website at premera.com. If you don't have access to the internet, please call customer service.

Definitions

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

Accidental Injury	Physical harm caused by a sudden, unexpected event at a certain time and place. Accidental injury does not mean any of the following: • An illness, except for infection of a cut or wound • Dental injuries caused by biting or chewing • Over-exertion or muscle strains
Adverse Benefit Determination	An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes: • A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage • A limitation on otherwise covered benefits • A clinical review decision • A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective • A decision related to compliance with protections against balance billing as defined by federal and state law
Affordable Care Act	The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
Ambulatory Surgical Center	A healthcare facility that's licensed or certified as required by the state it operates in and that meets all of the following: • It has an organized staff of physicians. • It has permanent facilities that are equipped and operated mainly for the purpose of performing surgical procedures. • It doesn't provide inpatient services or accommodations.
Applied Behavioral Analysis (ABA)	The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.
Autism Spectrum Disorders	Pervasive developmental disorders or a group of conditions having

	substantially the same characteristics as pervasive developmental disorders, as defined in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, as amended or reissued from time to time.
Benefit	What this plan provides for a covered service. The benefits you get are subject to this plan's cost shares.
Benefit Booklet	Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.
Calendar Year	The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on December 31 at midnight.
Claim	A request for payment from us according to the terms of this plan.
Clinical Trials	An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by one of the following: • An institutional review board that complies with federal standards for protecting human research subjects; and • The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers • 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
Congenital Anomaly	A marked difference from the normal structure of an infant's body part that's present from birth.
Contract	Contract describes the benefits, limitations, exclusions, eligibility, and other coverage provisions included in this plan.
Cosmetic Services	Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This includes drugs, services, or supplies to improve or alter the appearance of your skin or hair.
Cost Share	The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.
Covered Service	A service, supply or drug that is eligible for benefits under the terms of this Plan.
Custodial Care	Any part of a service, procedure, or supply that is provided primarily: • For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury • To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.
Dependent	The subscriber's spouse or domestic partner and any children who are on this plan.
Detoxification	Active medical management of substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance taken, repeated vital sign

	monitoring, and use of medication to manage intoxication or withdrawal. Observation without active medical management, or any service that is claimed to be detoxification but does not include active medical management, is not detoxification.
Doctor (also called "Physician")	A state-licensed: • Doctor of Medicine and Surgery (MD) • Doctor of Osteopathy (DO)
Effective Date	The date your coverage under this plan begins.
Emergency Medical Condition (also called "Emergency")	A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-emergency medical condition are minor cuts and scrapes.
Emergency Services	• A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services given in an emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health. • Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery. • Ambulance transport, as needed, in support of the services above
Endorsement	A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.
Essential Health Benefits	Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.
Experimental/Investigative Services	A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria: • A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have

	approval on the date the service is provided. • It is subject to oversight by an Institutional Review Board. • There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition. • It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. • Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies. Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).
Explanation of Benefits	An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.
Facility (Medical Facility)	A hospital, skilled nursing facility, approved treatment facility for 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 Health Agency	An organization that provides covered home health care services to a member.
Home Medical Equipment (HME)	Equipment ordered by a healthcare provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as “Durable Medical Equipment” or “DME”.
Hospice	A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill. Care is focused on comfort and not intended to cure or improve the medical or functional outcome of a patient’s condition or to prepare the patient for outpatient care settings.
Hospital	A healthcare facility that meets all of these criteria: • It operates legally as a hospital 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 providers that provides or supervises the care. • It has 24-hour nursing services provided by or supervised by registered nurses. A facility is not considered a hospital if it operates mainly for any of the purposes below: • As a rest home, nursing home, or convalescent home • As a residential treatment center or health resort • To provide hospice care for terminally ill patients • To care for the elderly

	• To treat substance use disorder or tuberculosis
Illness	A sickness, disease, or medical condition.
Injury	Physical harm caused by a sudden event at a specific time and place. It is independent of illness, except for infection of a cut or wound.
In-Network Pharmacy (In-Network Retail/In-Network Mail Order Pharmacy)	A licensed pharmacy which contracts with us or our Pharmacy Benefit Manager to provide prescription drug benefits.
Inpatient	Confined in a medical facility or as an overnight bed patient.
Lifetime Maximum	The maximum amount that Premera Blue Cross will provide during your lifetime.
Long-term Care Facility	A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.023, or assisted living facility licensed under chapter 18.20 RCW.
Maternity Care	Health services you get during pregnancy (before, during, and after birth) or for any condition caused by pregnancy. This includes the entire time you are pregnant and up to 45 days after birth.
Medical Equipment	Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.
Medically Necessary and Medical Necessity	Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must: • Agree with generally accepted standards of medical practice • Be clinically appropriate in type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease. • Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
Member (also called “You” or “Your”)	A person covered under this plan as a subscriber or dependent.
Mental Health Conditions	A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance use disorder.
Non-Contracted Provider	A provider that does not have a contract with us or with any of the other networks used by this plan.
Non-Participating Provider	A provider that is not in one of the provider networks stated in ***How Providers Affect Your Costs*** or is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.
Observation	Monitoring and evaluation at a Hospital or other facility in order to determine whether an inpatient stay is required.

Orthotic	A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.
Outpatient	Treatment received in a setting other than as inpatient in a medical facility.
Outpatient Surgical Center	A facility that's licensed or certified as required by the state it operates in and that meets all of the following: • It has an organized staff of physicians. • It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures. • It doesn't provide inpatient services or accommodations.
Pharmacy Benefit Manager	An entity that contracts with us to administer the ***Prescription Drugs*** benefit under this plan.
Plan	The benefits, terms, and limitations stated in this contract.
Premium	The monthly rates we establish as consideration for the benefits offered under this contract.
Prescription Drugs	Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription". Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by: One of the following standard reference compendia: • The American Hospital Formulary Service-Drug Information • The American Medical Association Drug Evaluation • The United States Pharmacopoeia-Drug Information • Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts). "Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling. Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.
Primary Care Provider (PCP)	A provider who both provides primary care and coordinates care to other medical services.
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 their employment. Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law. Covered categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met: The providers are: • Acupuncturists (LAc) (In Washington also called “East Asian Medicine Practitioners” (EAMP)) • Audiologists • Chiropractors (DC) • Counselors • Dental Hygienists (under the supervision of a DDS or DMD) • Dentists (DDS or DMD) • Denturists • Dietitians and Nutritionists (D or CD, or CN) • Gynecologists (MD) • Home Health Care, Hospice and Home Care Agencies • Marriage and Family Therapists • Massage Practitioners (LMP) • Midwives • Naturopathic Physicians (ND) • Nurses (RN, LPN, ARNP, or NP) • Nursing Homes • Obstetricians (MD) • Occupational Therapists (OTA) • Ocularists • Opticians (Dispensing) • Optometrists (OD) • Osteopathic Physician Assistants (OPA) (under the supervision of a DO) • Osteopathic Physicians (DO) • Pharmacists (RPh) • Physical Therapists (LPT) • Physician Assistants (PA) (under the supervision of an MD) • Physicians (MD) • Podiatric Physicians (DPM) • Psychologists (PhD) • Radiologic Technologists (CRT, CRTT, CRDT, CNMT) • Respiratory Care Practitioners

	• Social Workers • Speech-Language Pathologists The following healthcare facilities and other providers will also be considered providers for the purposes of this plan when they meet the requirements above. • Ambulance Companies • Ambulatory Diagnostic, Treatment and Surgical Facilities • Audiologists (CCC-A or CCC-MSPA) • Birthing Centers • Blood Banks • Board Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed in states that have specific licensure for behavior analysts • Community Mental Health Centers • Drug and Alcohol Treatment Facilities • Medical Equipment Suppliers • Hospitals • Kidney Disease Treatment Centers (Medicare-certified) • Psychiatric Hospitals • Speech Therapists (Certified by the American Speech, Language and Hearing Association) In states other than Washington, “provider” means healthcare practitioners and facilities that are licensed or certified consistent with the laws and regulations of the state in which they operate. This plan makes use of provider networks as explained in ***How Providers Affect Your Costs***.
Psychiatric Condition	A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance use disorder.
Reconstructive Surgery	Is surgery: • That restores features damaged as a result of injury or illness • To correct a congenital deformity or anomaly
Rehabilitation Therapy	Rehabilitation therapy or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition. Rehabilitation therapy includes physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope of their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.
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, Lincoln, Pacific, Pierce, Spokane, and Yakima.
Services	Procedures, surgeries, consultations, advice, diagnosis, referrals,

	treatment, supplies, drugs, devices, technologies or places of service.
Skilled Nursing Care	Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.
Skilled Nursing Facility	A medical facility licensed by the state to provide nursing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.
Specialist	A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
Spouse	• An individual who is legally married to the subscriber. • An individual who is a domestic partner of the subscriber.
Subscriber	The person in whose name the plan is issued.
Substance Use Disorder Conditions	Substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.
Urgent Care	Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away, but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.
Virtual Care	Healthcare services provided through the use of online technology, telephonic and secure messaging of member-initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused. 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

Notice of availability and nondiscrimination **800-607-0546 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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