Parametrix, Inc.

Your Choice™ *

1037345

PREMERA | BLUE CROSS

INTRODUCTION

*This booklet is for members of the Parametrix, Inc. medical plan. This plan is self-funded by Parametrix, Inc., which means that Parametrix, Inc. is financially responsible for the payment of plan benefits. Parametrix, Inc. ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

Parametrix, Inc. has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. Parametrix, Inc. has delegated to Premera Blue Cross the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent stated in our administrative services contract with the Group. Premera Blue Cross does not insure the benefits of this plan.

In this booklet Premera Blue Cross is called the "Claims Administrator." This booklet replaces any other benefit booklet you may have.

If any provision of this Plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.

Group Name:	Parametrix, Inc.
Effective Date:	January 1, 2024
Group Number:	1037345
Plan:	Your Choice (Non-Grandfathered)
Certificate Form Number:	10373450124YC

Discrimination is Against the Law

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

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្តែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው፡ 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

HOW TO USE THIS BOOKLET

This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **Summary Of Your Costs** — A quick overview of what the plan covers and your costs
- **How Providers Affect Your Costs** — how using in-network providers will cut your costs
- **Important Plan Information** — Explains the allowed amount and gives you details on the deductible, copays, coinsurance, and the out-of-pocket maximum.
- **Covered Services** — details about what's covered
- **Prior Authorization** – Describes the plan's prior authorization and emergency admission notification requirements.
- **Exclusions and Limitations** — services that are either limited or not covered under this plan
- **Who Is Eligible For Coverage?** – eligibility requirements for this plan
- **How Do I File A Claim?** — step-by-step instructions for claims submissions
- **Complaints And Appeals** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: "You" and "your" refer to members under this plan. "We," "us" and "our" refer to Premera Blue Cross.

FOR MORE INFORMATION

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

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

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

Online information about your plan is at your fingertips whenever you need it

You can use our website to:

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

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SUMMARY OF YOUR COSTS

This section shows a summary table of the care covered by your plan. It also explains the amounts you pay. **This section does not go into all the details of your coverage. See *Covered Services* to learn more**.

First, here is a quick look at how this plan works. Your costs are subject to all of the following.

- **Networks**. To help control the cost of your care, this plan uses Premera's Heritage network in Washington. You may be able to save money if you use an in-network provider. For more network details, see ***How Providers Affect Your Costs***.
- **Allowed amount**. This is the most this plan allows for a covered service. See ***Important Plan Information*** for details. For some covered services, you have to pay part of the allowed amount. This is called your **cost share**. This plan's cost shares are explained below. You will find the amounts in the summary table.
- **Copays**. These are set dollar amounts you pay at the time you get some services. If the amount billed is less than the copay, you pay only the amount billed. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary table. The deductible does not apply to most services that require a copay. Any exceptions are shown in the table.

	In-Network Providers
Professional visit copay	$25

- **Deductible**. The total allowed amount you pay in each year for in-network and out-of-network providers' care combined before this plan starts to make payments for your covered healthcare costs. You pay down the deductible with each claim.

	In-Network Providers	**Out-of-Network Providers**
Individual deductible	$1,250	Shared with In-Network
Family deductible	$2,500	Shared with In-Network

- **Coinsurance**. For some healthcare, you pay a percentage of the allowed amount, and the plan pays the rest. This booklet calls your percentage “coinsurance.” You pay less coinsurance for many benefits when you use an in-network provider. Your coinsurance is shown in the summary table.

	In-Network Providers	**Out-of-Network Providers**
Coinsurance	20%	40%

- **Out-of-pocket maximum**. This is the most you pay each calendar year for any deductibles, copays and coinsurance. Not all the amounts you have to pay count toward the out-of-pocket maximum. See ***Important Plan Information*** for details.

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$7,000	$8,000
Family out-of-pocket maximum	$14,000	$16,000

- **Prior Authorization**. Some services must be approved in advance before you get them, in order to be covered. See ***Prior Authorization*** for details about the types of services and time limits. Some services have special rules.

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

SUMMARY TABLE

The summary table below shows plan limits and what you pay (your cost shares) for covered services. Facility in the table below means hospitals or other medical institutions. **Professional** means doctors, nurses, and other people who give you your care. **No charge** means that you do not pay any deductible, copay or coinsurance for covered services. **No cost shares** means that you do not pay any deductible, copay or coinsurance for covered services, the provider can bill you for amounts over the allowed amount. A non-participating provider can bill you for amounts over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law.

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture • Office and Clinic Visits calendar year visit limit: 12 visits Substance use disorder: no limit	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Visits outside an office setting	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Allergy Testing And Treatment	No charge	Deductible, then 40% coinsurance
Ambulance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Assisted Reproduction Lifetime maximum: $20,000 This benefit is only provided for the eligible subscriber and/or spouse/domestic partner on this plan. Benefits are not provided for dependent children. For coverage of prescription drugs, see the ***Prescription Drug*** benefit		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Inpatient facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
• Outpatient surgery center	$50 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Surgery and other professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Testing	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Blood Products and Services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Cellular Immunotherapy And Gene Therapy 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.	Covered as any other in-network service	Covered as any other out-of-network service
Chemotherapy and Radiation Therapy Professional and facility services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Clinical Trials Covers routine patient care during the trial You may have additional costs for other services such as x-rays, lab, prescription drugs, and hospital facility charges. See those covered services for details.	Covered as any other service	Covered as any other service

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	 OUT-OF-NETWORK PROVIDERS
Dental Injury and Facility Anesthesia		
• **Dental Anesthesia** (See ***Dental Injury and Facility Anesthesia*** benefit for details.)		
• Inpatient facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
• Outpatient surgery center	$50 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Anesthesiologist	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• **Dental Injury**		
• Exams to determine treatment needed	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Treatment	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Diagnostic colonoscopies, including barium enema See ***Preventive Care*** for additional information on preventive screening services.	No charge	Deductible, then 40% coinsurance
Diagnostic X-Ray, Lab, And Imaging for medical conditions or symptoms		
• Tests, lab, imaging and scans	20% coinsurance, deductible waived	40% coinsurance, deductible waived
• Diagnostic and supplemental breast exams	No charge	Deductible, then 40% coinsurance
Dialysis For permanent kidney failure. See the ***Dialysis*** benefit for details.	Same as other covered services	Same as other covered services
Emergency Room		
• Facility charges You may have additional costs for other services. Examples are X-rays or lab tests. See those covered services for details. 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.	$75 copay per visit, then Deductible, then 20% coinsurance	$75 copay per visit, then In-network deductible, then 20% coinsurance
• Professional services	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	 OUT-OF-NETWORK PROVIDERS
Foot Care such as trimming nails or corns, when medically necessary due to a medical condition		
• In an office or clinic	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• All other settings	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Gender Affirming Care		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Other professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
Hearing Care For hearing loss, often due to age or noise exposure.		
Hearing Exams		
Limit each calendar year: 1 exam/test (Copay does not apply to a separate visit for testing. Your copay does not count toward your out-of-pocket maximum.)	$25 copay per visit, deductible waived	$25 copay per visit, deductible waived
Hearing Hardware		
Limit per 3-calendar year period: $5,000	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Home Health Care calendar year visit limit: 130 visits		
• Home visits • Prescription drugs billed by the home health agency	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies • Sales tax for covered items • Foot orthotics and therapeutic shoes; calendar year limit: $300 diabetes-related: no limit • Medical vision hardware for members 19 or older (see the ***Vision Hardware*** benefit for members under 19)	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	 OUT-OF-NETWORK PROVIDERS
Hospice Care Lifetime limit for terminal illness: 6 months Lifetime limit for non-terminal illness: none Inpatient stay limit: 10 days Home visits: Unlimited Respite care: 240 hours lifetime max		
• Inpatient facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
• Home and respite care	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Prescription drugs billed by the hospice	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Hospital		
• Inpatient Care		
• Professional	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Facility	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
• Outpatient Care		
• Professional	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Facility	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Infusion Therapy	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Mastectomy and Breast Reconstruction		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Surgery and other professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
Maternity Care Care during pregnancy, childbirth and after the baby is born. See the ***Preventive Care*** benefit for routine exams and tests during pregnancy.		
• Professional care	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient hospital	Deductible, then 20% coinsurance	$200 copay, then deductible, and 40% coinsurance
• Birthing centers and short-stay hospitals	$50 copay, deductible waived	$200 copay, then deductible, and 40% coinsurance
• Abortion	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Medical Foods includes phenylketonuria (PKU)	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Medical Transportation Travel and lodging are covered up to the IRS limitations. Prior approval required**.**		
For transplants: limit per transplant: $7,500	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
For cellular immunotherapy and gene therapy: $7,500 per episode of care.	No charge	No charge
Special criteria are required for travel benefits to be provided. See the benefit for coverage details.		
Mental Health Care		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Other professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient and residential facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
• Outpatient facility care	20% coinsurance, deductible waived	Deductible, then 40% coinsurance
Neurodevelopmental (Habilitation) Therapy See the ***Mental Health Care*** benefit for therapies for mental conditions such as autism.		
• Outpatient care calendar year visit limit: 45 visits		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Other outpatient services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient care calendar year day limit: None	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
Newborn Care		
• Inpatient care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Other outpatient services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Orthognathic Surgery (Jaw Augmentation or Reduction) lifetime limit: None, for congenital anomalies the benefit limit maximum does not apply.		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Surgery and other professional care	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Outpatient surgery facility care	$50 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Inpatient hospital care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	YOUR SHARE OF THE ALLOWED AMOUNT OUT-OF-NETWORK PROVIDERS
Prescription Drug In no case will you pay more than the cost of the drug or supply.		
Covered Drugs	**In-Network Retail Pharmacy** (up to a 100-day supply per prescription or refill)	**Out-Of-Network Retail Pharmacy**
• Generic drugs	$10 copay	$10 copay plus 40% coinsurance
• Preferred brand name drugs	$30 copay	$30 copay plus 40% coinsurance
• Non-preferred brand name drugs	$50 copay	$50 copay plus 40% coinsurance
	In-Network Mail-Order Pharmacy (up to a 100-day supply per prescription or refill)	**Out-Of-Network Mail-Order Pharmacy**
• Generic drugs	$25 copay	Not covered
• Preferred brand name drugs	$75 copay	Not covered
• Non-preferred brand name drugs	$125 copay	Not covered
**Your cost shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug. The deductible does not apply. Cost shares for covered prescription insulin drugs apply toward the deductible*.		
	In-Network Retail or In-Network Mail-Order Pharmacy	**Out-Of-Network Retail Pharmacy**
PV Core Plus **Preventive Drugs**	No charge	Same as out-of-network retail
	In-Network Retail Pharmacy	**Out-Of-Network Retail Pharmacy**
Specialty Drugs (per prescription or refill).	Same as retail	Not covered
Exceptions	**In-Network Retail or In-Network Mail Order Pharmacy**	**Out-Of-Network Retail Pharmacy**
• Needles and syringes purchased with diabetic drugs	No charge	No cost shares
• Certain prescription drugs and generic over-the-counter drugs to break a nicotine habit	No charge	Same as out-of-network retail
• Drugs on the Affordable Care Act's preventive drug list	No charge	Same as out-of-network retail
• Contraceptive drugs, devices and supplies (prescription and over-the-counter). Includes emergency contraceptive.	No charge	Same as out-of-network retail

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Preventive Care (Limits on how often services are covered and who services are recommended for may apply.)		
• Preventive exams, including vision and oral health screening for members under 19, diabetes and depression screening	No charge	Deductible, then 40% coinsurance
• Fall prevention for members 65 and older	No charge	Deductible, then 40% coinsurance
• Immunizations in the provider's office	No charge	Deductible, then 40% coinsurance
• Flu shots and other seasonal immunizations at a pharmacy or mass immunizer location	No charge	No cost shares
• Travel immunizations at a travel clinic or county health department	No charge	No cost shares
• Health education and training (outpatient)	No charge	Not covered
• Diabetes health education	No charge	40% coinsurance, deductible waived
• Nicotine habit-breaking programs	No charge	Deductible, then 40% coinsurance
• Nutritional counseling and therapy	No charge	Deductible, then 40% coinsurance
• Pregnant member's care (includes breast-feeding support and post-partum depression screening)	No charge	Deductible, then 40% coinsurance
• Screening tests (includes prostate and cervical cancer screening)	No charge	Deductible, then 40% coinsurance
• Screening mammograms	No charge	Deductible, then 40% coinsurance
• Colorectal cancer screening *Clinical age and frequency limitations do not apply to colorectal cancer screening*	No charge	Deductible, then 40% coinsurance
• Contraceptive and sterilization.	No charge	Deductible, then 40% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Professional Visits and Services You may have extra costs for other services like lab tests and facility charges. Also see ***Allergy Testing And Treatment*** and ***Therapeutic Injections***.		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Surgery performed in an office setting	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Electronic visits (e-visits)	$25 copay per visit, deductible waived	Not covered
• Other professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Coverage for office visits throughout this plan includes real-time visits via online and telephonic methods with your doctor or other provider (telemedicine) when appropriate.		
Psychological and Neuropsychological Testing	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Rehabilitation Therapy • Outpatient Care calendar year visit limit: 45 visits No limit for cardiac or pulmonary rehabilitation programs, or similar programs for cancer or other chronic conditions.		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Other outpatient services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient Care calendar year day limit: None	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
Skilled Nursing Facility Care calendar year day limit: 60 days	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
Sleep Studies		
In the member's home (members 19 or older)	No charge	Deductible, then 40% coinsurance
In an outpatient facility	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Spinal and Other Manipulations calendar year visit limit: 30 visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
Substance Use Disorder		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Other professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient care and residential facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
• Outpatient facility care	20% coinsurance, deductible waived	Deductible, then 40% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Surgery (includes anesthesia and blood transfusions) See the ***Hospital*** and ***Surgical Center Care – Outpatient*** benefits for facility charges.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Vasectomy	No charge	Deductible, then 40% coinsurance
Surgical Center Care – Outpatient	$50 copay, deductible waived	Deductible, then 40% coinsurance
Temporomandibular Joint Disorders (TMJ) Care		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Other professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
• Inpatient facility care	Deductible, then 20% coinsurance	$200 copay, then deductible, then 40% coinsurance
Therapeutic Injections	No charge	Deductible, then 40% coinsurance
Transplants (Includes donor search and donation costs.)		
• Inpatient facility care	Deductible, then 20% coinsurance	Not covered*
• Office and clinic visits	$25 copay per visit, deductible waived	Not covered*
• Surgery and other professional services	Deductible, then 20% coinsurance	Not covered*
**All Approved Transplant Centers covered at the in-network level*		
Urgent Care Services at an urgent care center. See ***Diagnostic X-Ray, Lab, And Imaging*** for tests received while at the center. Your deductible and coinsurance apply to facility charges.		
• Freestanding urgent care centers	$25 copay per visit, deductible waived	Deductible, then 40% coinsurance
• Urgent care centers attached to or part of a hospital	$75 copay per visit, then Deductible, then 20% coinsurance	$75 copay per visit, then In-network deductible, then 20% coinsurance
Virtual Care Interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment.		
Virtual general medical visits	$10 copay per visit, deductible waived	n/a
Virtual mental health visits	$25 copay per visit, deductible waived	n/a
Virtual substance use disorder visits	$25 copay per visit, deductible waived	n/a
Virtual rehabilitative care visits	$25 copay per visit, deductible waived	n/a

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Vision Care • **Vision Exams** Calendar year limit: one complete exam. • Members 19 or older (exam copay does not count toward your out-of-pocket maximum)	$25 copay per visit, deductible waived	$25 copay per visit, deductible waived
• Members younger than 19 Also covered is 1 comprehensive low vision exam and 4 follow-up visits in a 5-calendar year period as needed	$25 copay per visit, deductible waived	$25 copay per visit, deductible waived
• **Vision Hardware** • Members 19 And Older Limit per calendar year: $400	No charge	No cost shares
• Members Under 19 • Glasses (frames and lenses), lens features covered are polycarbonate lenses and scratch resistant coating) Calendar year limit: 1 pair (lenses and frames)	No charge	No cost shares
• Contact lenses Calendar year limit: Instead of glasses, 1 pair of non-disposable lenses or a 12-month supply of disposable lenses	No charge	No cost shares
• Contact lenses and glasses required for medical reasons such as aphakia or keratoconus	No charge	No cost shares
• Low vision devices, high power glasses, magnifiers and telescopes when medically necessary	No charge	No cost shares
Weight Management (surgical and non-surgical)	Covered as any other in-network service	Covered as any other out-of-network service

HOW PROVIDERS AFFECT YOUR COSTS

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

In-Network Providers

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

In-Network providers are:

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

In-Network pharmacies are available nationwide.

In-Network providers provide medical care to members at negotiated fees. These fees are the allowed amounts for in-network providers. When you receive covered services from an in-network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). This means lower cost shares for you, as shown in the ***Summary Of Your Costs***. In-Network providers will not charge you more than the allowed amount for covered services. This means that your portion of the charges for covered services will be lower.

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

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

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

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.

Continuity Of Care

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

COC applies in these situations:

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

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

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

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

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

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

- The 90th day after we notified you that your provider's contract ended
- The day after you complete the active course of treatment entitling you to continuity of care
- If you are pregnant, and become eligible for continuity of care, you can continue with your provider throughout your pregnancy, plus 8 weeks of 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***.

Non-Participating Providers

Non-participating providers are either (1) providers that are not in one of the networks (Out-Of-Network) shown above or (2) providers that do not have a contract with us (Non-Contracted).

- **Out-of-Network** Some providers in Washington have a contract with but are not in the Heritage network. In cases where this plan covers services from these providers, they will not bill you for any 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.
- There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers are called "non-contracted" providers in this booklet. Their covered services are based on a lower allowed amount. See ***Important Plan Information***. "Non-contracted" providers also have the right to charge you more than the allowed amount for a covered service. You may also be required to submit the claim yourself. See ***How Do I File A Claim?*** for details.

Amounts in excess of the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Services you receive in an in-network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are out-of-network providers. When you receive services from these out-of-network providers, you may be responsible for amounts over the allowed amount as explained above.

In-Network Benefits For Out-Of-Network Providers

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

- Emergency services for an emergency medical condition. See the Definitions section for definitions of these terms. This plan provides worldwide coverage for emergency services.

  The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is an in-network provider. Emergency services furnished by an out-of-network provider will be reimbursed at the in-network benefit level. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowed amount.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Heritage provider who doesn't have admitting privileges at a Heritage hospital.
- Covered emergency services received from providers located outside the United States.

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

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, federal law protects you from balance billing for:

Emergency Services from a nonparticipating hospital or facility or from a nonparticipating provider at the hospital or facility.

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

Non-emergency services from a **nonparticipating 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 law regarding balance billing do not apply for these services.

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

For the above services, you will pay no more than the plan's in-network cost shares. See the ***Summary of Your Costs***. Premera Blue Cross will work with the nonparticipating 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.

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 an emergency medical condition. See the ***Definitions*** section for definitions of these terms. This plan provides worldwide coverage for emergency services.

  The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services has a contract

with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.

- Facility and hospital-based provider services received from a hospital that has a provider contract with Premera Blue Cross.
- Covered emergency services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

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

IMPORTANT PLAN INFORMATION

This section of your booklet explains the types of expenses you must pay for covered services before the benefits of this plan are provided. (These are called “cost shares” in this booklet.) To prevent unexpected out-of-pocket expenses, it’s important for you to understand what you’re responsible for.

The allowed amount is also explained.

You'll find the dollar amounts for these expenses and when they apply in the ***Summary Of Your Costs***.

COPAYMENTS (COPAYS)

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

Professional Visit Copay You pay this copay for each visit to the provider’s office. Certain services in the provider’s office don’t require a copay. However, the Professional Visit Copay may apply if you have a consultation with the provider or receive other services. Separate copays will apply if you see more than one provider on the same day. But only one copay per provider per day will apply. If you receive multiple services from the same provider in the same visit and the copay amounts are different, then the highest copay will apply.

Your copay amounts are shown in the ***Summary Of Your Costs***.

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won’t exceed the allowed amount. See the ***Allowed Amount*** subsection below in this booklet.

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

Individual Deductible

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

Family Deductible

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

What Doesn’t Apply To The Calendar Year Deductible?

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

- Amounts that exceed the allowed amount

- Charges for excluded services
- The difference in cost between a brand name drug and an equivalent generic drug when the plan requires the generic drug to be dispensed in place of the brand name drug.
- Copays
- The coinsurance for in-network pharmacies stated in the ***Summary Of Your Costs***

COINSURANCE

"Coinsurance" is a defined percentage of allowed amounts for covered services and supplies you receive. It's the percentage you're responsible for, not including copays and the calendar year deductible, when the plan provides benefits at less than 100% of the allowed amount. You will find your coinsurance in the ***Summary Of Your Costs***.

OUT-OF-POCKET MAXIMUM

The "individual out-of-pocket maximum" is the maximum amount, made up of the cost shares below, that each individual could pay each calendar year for certain covered services and supplies. Refer to the ***Summary Of Your Costs*** for the amount of out-of-pocket maximums you're responsible for.

Once the out-of-pocket maximum has been satisfied, the benefits of this plan will be provided at 100% of allowed amounts for the remainder of that calendar year for covered services that are subject to the maximum.

The plan has separate out-of-pocket maximums for in-network and out-of-network providers. **It could happen that you satisfy one of these maximums before the other. If this happens, you still have to pay cost shares that apply to the second out-of-pocket maximum until it, too, is met.**

Cost shares that apply to the out-of-pocket maximum are:

- Your coinsurance
- The calendar year deductible

  Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay any other cost shares shown in the ***Summary Of Your Costs*** until your individual out-of-pocket maximum is reached.
- Copays
- The difference in cost between a brand name drug and an equivalent generic drug when the plan requires the generic drug to be dispensed in place of the brand name drug.
- The reduction in cost shares resulting from a drug discount program.

There are some exceptions. Expenses that do not apply to the out-of-pocket maximum are:

- Charges above the allowed amount
- Charges not covered by the plan
- Copays for exams covered under the Vision Exams benefit for members 19 or older.
- Copays for exams covered under the Hearing Exams benefit

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

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 unless otherwise specified in the Group's administrative services agreement with us. The allowed amount is described below. There are different rules for dialysis due to end-stage renal disease and for certain services as described below. These rules are shown below the general rules.

General Rules

- **Providers In Washington and Alaska Who Have Agreements With Us**

  For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this plan.

  Your liability for any applicable calendar year deductibles, coinsurance, copays and amounts applied toward benefit maximums will be calculated on the basis of the allowed amount.

- **Providers Outside The Service Area Who Have Agreements With Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside the service area, allowed amounts are determined as stated in the ***What Do I Do If I'm Outside Washington And Alaska*** section (***Out-Of-Area Care***) in this booklet.

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

  Except as stated below, the allowed amount for providers in the service area that don't have a contract with us is the least of the three amounts shown below. The allowed amount for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

  - An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us
  - 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
  - The provider's billed charges. Note: Ground ambulances are always paid based on billed charges.

  If applicable law requires a different allowed amount than the least of the three amounts above, this plan will comply with that law.

Dialysis Due To End Stage Renal Disease

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

  The allowable charge is the amount explained above in this definition.

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

  The amount the plan allows for dialysis will be no less than 125% of the Medicare-approved amount and no more than 90% of billed charges.

Emergency Services

Consistent with the requirements of the Affordable Care Act, the allowed amount for non-contracted providers will be the greatest of the following amounts:

- The median amount that Heritage network providers have agreed to accept for the same services
- The amount Medicare would allow for the same services
- The amount calculated by the same method the plan uses to determine payment to out-of-network providers

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

When you receive services from providers that **don't** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowed amount, and for your normal share of the allowed amount. See the ***Summary Of Your Costs*** for further detail.

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

The allowed amount will be the amount allowed for out-of-network providers even when the provider's services are covered at the in-network benefit level.

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

COVERED SERVICES

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be medically necessary (see the ***Definitions*** section in this booklet) and must be furnished in a medically necessary setting.
- It 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 furnished by a "provider" (see the ***Definitions*** section in this booklet) 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. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at **www.premera.com** or by calling Customer Service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Refer to the actual benefit provisions throughout this section and the ***Exclusions and Limitations*** section for a complete description of covered services and supplies, limitations and exclusions. You will find limits on days or visits and dollar limits in the ***Summary Of Your Costs***.

The ***Summary Of Your Costs*** also explains your cost shares under each benefit.

Acupuncture

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

This benefit covers acupuncture to:

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

Note: Acupuncture services when provided for substance use disorder conditions do not apply to the ***Acupuncture*** benefit visit limit.

Allergy Testing and Treatment

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

This benefit covers:

- Testing
- Allergy shots
- Serums

Ambulance

This benefit covers:

- Transport to the nearest facility that can treat your condition
- Medical care you get during the trip
- Transport from one medical facility to another as needed for your condition

- Transport to your home when medically necessary

These services are only covered when:

- Any other type of transport would put your health or safety at risk
- The service is from a licensed ambulance
- It is for the member who needs transport

Air or sea emergency medical transportation is covered when:

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

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

This benefit does not cover:

- Services from an unlicensed ambulance

Assisted Reproduction

This benefit covers assisted reproduction methods. An example is in-vitro fertilization. Also covered are procedures to undo sterilization surgery. Related imaging and lab tests are also covered. These services are not covered under other benefits of this plan.

Take-home drugs to treat infertility or that are required for assisted reproduction procedures are covered under the ***Prescription Drug*** benefit. However, these drugs are subject to the maximum for this benefit shown in the ***Summary Of Your Costs***.

This benefit doesn't cover:

- Testing to determine if a member is infertile. Such tests are covered under the ***Diagnostic X-Ray, Lab, And Imaging*** benefit.
- Medical services to diagnose and correct medical conditions that may cause infertility, including tests to monitor the outcomes. See the ***Diagnostic X-Ray, Lab, And Imaging*** and ***Surgery*** benefits.

Blood Products and Services

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

Cellular Immunotherapy And Gene Therapy

Benefits are provided for medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy. Services must meet Premera's medical policy. You can access our medical policies by contacting Customer Service or going to **premera.com**. Services also require prior authorization. See ***Prior Authorization***.

Chemotherapy And Radiation Therapy

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

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

This benefit covers:

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

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

Clinical Trials

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

This benefit covers qualified clinical trial medical services and drugs that are already covered under this plan. The clinical trial must be suitable for your health condition. You also have to be enrolled in the trial at the time of treatment.

Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Professional Visits And Services*** and if you have a lab test, it's covered under ***Diagnostic X-Ray, Lab, And Imaging***.

This benefit doesn't cover:

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

Dental Injury and Facility Anesthesia

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

Dental Anesthesia

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

This benefit covers:

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

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

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

Dental Injury

Treatment of dental injuries to teeth, gum and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment
- Oral surgery

This benefit is covered on sound and natural teeth that:

- Do not have decay

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

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

Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Professional Visits And Services***, and if you have a lab test it's covered under ***Diagnostic X-ray, Lab and Imaging***.

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

Diagnostic X-Ray, Lab, And Imaging

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

For more information about what services are covered as preventive see ***Preventive Care***. A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

Covered services include:

- Bone density screening for osteoporosis
- Cardiac testing
- Pulmonary function testing
- Diagnostic imaging and scans such as x-rays
- Lab services
- Mammograms (including 3-D mammograms) for a medical condition
- Neurological and neuromuscular tests
- Pathology tests
- Echocardiograms
- Ultrasounds
- Diagnosis and treatment of underlying medical conditions that may cause infertility
- Computed Tomography (CT) scan
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan

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, or breast ultrasound, 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 or breast cancer

For additional details see the following benefits:

- Emergency Room
- Hospital

- Maternity Care
- Preventive Care
- Genetic testing may be covered in some cases. Call customer service before seeking testing, since it may require Prior Authorization. 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.

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

This benefit does not cover non-diagnostic testing or screening required for employment, schooling, or public health reasons that is not for the purpose of treatment.

Dialysis

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

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. If the dialysis services are provided by a non-contracted provider then you will owe the difference between the non-contracted provider's billed charges and the payment the plan will make for the covered services. See ***Allowed Amount*** in ***Important Plan Information*** for more information.

Emergency Room

This benefit covers:

- Emergency room and provider services
- Equipment, supplies and drugs used in the emergency room
- Services and exams used for stabilizing an emergency medical condition, including mental health, or substance use disorder condition. This includes emergency services arising from complications from a service that was not covered by the plan.
- Diagnostic tests performed with other emergency services
- Emergency detoxification

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

Foot Care

This benefit covers the following medically necessary foot care services that need care from a provider:

- Foot care for members with impaired blood flow to the legs and feet when it puts the member at risk
- Treatment of corns, calluses and toenails

This benefit does not cover routine foot care, such as trimming nails or removing corns and calluses that do not need care from a provider.

Gender Affirming Care

Benefits for medically necessary gender affirming care services are subject to the same cost shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages. To find the amounts you are responsible for, see the ***Summary Of Your Costs*** earlier in this booklet.

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

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

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

Hearing Care

Hearing Exams

Hearing exam services include:

- Examination of the inner and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- Hearing testing services, including the use of calibrated equipment.

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

Hearing Hardware

To receive your hearing hardware benefit:

- You must be examined by a licensed physician (MD or DO) or audiologist (CCC-A or CCC-MSPA) before obtaining hearing aids
- You must purchase a hearing aid device

Benefits are provided for the following:

- Hearing aids (monaural or binaural) prescribed as a result of an exam
- Ear molds as necessary to maintain optimal fit
- The hearing aid instruments, including bone conduction hearing devices
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty, when provided by the manufacturer
- A follow-up consultation within 30 days following delivery of the hearing aids with either the prescribing physician or audiologist
- Auditory training, fitting (including adjustment), repairs, servicing, and alteration of hearing aid equipment purchased under this benefit

For the purpose of this benefit, coverage for members under 18 years of age is available only after the member has received medical clearance with the preceding six months from:

- an otolaryngologist for an initial evaluation of hearing loss; or
- a licensed physician, which indicated there has not been a substantial change in clinical status since the initial evaluation by an otolaryngologist.

This benefit doesn't cover:

- Hearing aids purchased before your effective date of coverage under this plan
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.
- Cochlear implants. See the ***Surgery*** and ***Rehabilitation Therapy*** benefits.

Home Health Care

General Home Health Care

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

The following are covered under the ***Home Health Care*** benefit:

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

Only the following employees of a home health agency are covered:

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A social worker

Skilled Hourly Nursing

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

Home health care can be a substitute for hospitalization or inpatient care if hospitalization or inpatient care is medically necessary and such home care:

- can be provided at equal or lesser cost;
- is the most cost-effective setting and appropriate
- is with your consent and recommended by your attending physician or licensed health care provider that such care will adequately meet your needs.

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

The ***Home Health Care*** benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature.
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food

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

This benefit covers:

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

Covered items include:

- Wheelchairs
- Hospital beds
- Traction equipment
- Ventilators
- Diabetic equipment, such as an insulin pump

Medical Supplies such as:

- Dressings
- Braces
- Splints
- Rib belts
- Crutches
- Blood glucose monitor and supplies
- Supplies for an insulin pump

Medical Vision Hardware for members age 19 and older to correct vision due to the following medical eye conditions:

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

Medical vision hardware for members under age 19 is covered under ***Vision Hardware***.

External Prosthetics and Orthotic Devices used to:

- Replace absent body limb and/or
- Replace broken or failing body organ

Orthopedic Shoes and Shoe Inserts

Orthopedic shoes for the treatment of complications from diabetes or other medical disorders that cause foot problems.

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

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs. These services are covered under ***Prescription Drug***.
- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Over bed tables, elevators, vision aids, and telephone alert systems

- Over-the-counter orthotic braces and/or cranial banding
- Non-wearable external defibrillators, trusses and ultrasonic nebulizers
- Blood pressure cuffs/monitors (even if prescribed by a physician)
- Enuresis alarm
- Compression stockings which do not require a prescription
- Physical changes to your house or personal vehicle
- Orthopedic shoes used for sport, recreation or similar activity
- Penile prostheses
- Routine eye care
- Prosthetics, intraocular lenses, equipment or devices which require surgery. These items are covered under the ***Surgery*** benefit.

Hospice Care

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

The plan provides benefits for covered services furnished and billed by a hospice that is Medicare-certified or is licensed or certified by the state it operates in. See the ***Summary Of Your Costs*** for limits.

Covered employees of a hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a social worker.

The ***Hospice Care*** benefit covers:

- Hospice care for a terminally ill member, for up to 6 months. Benefits may be provided for up to an additional 6 months of care when needed. The initial 6-month period starts on the first day of covered hospice care.
- Palliative care for a member who has a serious or life-threatening condition that is not terminal. Coverage of palliative care can be extended based on the member's specific condition. Coverage includes expanded access to home-based care and care coordination.

Covered services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. This includes housekeeping done by a home health aide that is included in the written plan of care.
- **Respite care** to relieve anyone who lives with and cares for the terminally ill member.
- **Inpatient hospice care** This benefit provides for inpatient services and supplies used while you’re a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.
- **Insulin and Other Hospice Provider Prescribed Drugs** Benefits are provided for prescription drugs and insulin furnished and billed by a hospice.

This benefit doesn’t cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, transportation, and household supplies

Hospital

This benefit covers:

- Inpatient room and board

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

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

You pay out-of-network cost-shares if you get care from a provider not in your network. You will not be balanced billed for certain services provided by a non-participating provider. See ***How Providers Affect Your Costs*** for details.

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

This benefit does not cover:

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

Infusion Therapy

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

Infusion examples include:

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

This benefit covers:

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

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

Mastectomy and Breast Reconstruction

Benefits are provided for mastectomy necessary due to disease, illness or injury.

This benefit covers:

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

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

Maternity Care

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

Facility Care

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

This benefit also covers medically necessary supplies related to home births.

Professional Care

This benefit covers:

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

Note: Attending provider as used in this benefit means a provider such as a physician (MD or DO), a physician's assistant, a certified nurse midwife (CNM), a licensed midwife or an advanced registered nurse practitioner (ARNP). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. See the ***Surgery*** benefit for details on surgery coverage.

See the ***Preventive Care*** benefit for preventive care during and after pregnancy.

This benefit covers medically necessary donor human milk obtained from a milk bank for inpatient use when ordered by licensed healthcare provider.

This plan does not cover elective abortion.

Medical Foods

Medical foods are foods that are specially prepared to be consumed or given directly into the stomach by feeding tube under strict supervision of a doctor. They provide most of a person's nutrition. They are designed to treat a specific problem that can be detected using medical tests.

This benefit covers:

- Dietary replacement to treat inborn errors of metabolism (example phenylketonuria (PKU))
- Medically necessary elemental formula for eosinophilic gastrointestinal associated disorder
- Other severe conditions when your body cannot take in nutrient from food in the small intestine (malabsorption) disorder
- Disorders where you cannot swallow due to a blockage or a muscular problem and need to be fed through a tube

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

This benefit does not cover:

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

Medical Transportation

This plan provides benefits for travel and lodging only for certain covered services as described below. The member must live more than 50 miles away from the provider performing the services, unless transplant protocols require otherwise. Prior approval is required.

- Travel related to the covered transplants named in the ***Transplants*** benefit. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members not in the

hospital and for their companions. The member getting the transplant must live more than 50 miles from the transplant facility unless treatment protocols require the member to remain closer to the transplant center.

- Travel for the member and one companion for cellular immunotherapy and gene therapy. See ***Cellular Immunotherapy And Gene Therapy***.

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

Benefits are provided for:

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

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The mileage limits and requirements can change if IRS regulations change. Please go to the IRS website, **www.irs.gov**, for details. This summary is not and should not be assumed to be tax advice.

Companion Travel

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.

Reimbursement of Travel Claims

Transplants: You must pay for all travel expenses yourself and submit a Claim Reimbursement Form.

Cellular Immunotherapy, and Gene Therapy: You must pay for all travel expenses yourself and submit a Claim Reimbursement Form.

A separate Claim Reimbursement Form is needed for each patient and each commercial carrier or transportation service used. You can get Claim Reimbursement Forms on our website at **premera.com**. You can also call us for a copy of the form.

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

- A copy of the detailed itinerary as issued by the transportation carrier, travel agency or online travel website. The itinerary must identify the names of the passengers, the dates of travel and total cost of travel, and the origination and final destination points.
- Receipts for all covered travel expenses

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

This benefit does not cover:

- Charges and fees for booking changes
- Cancellation fees
- First class airline fees
- International travel
- Lodging at any establishment that is not commercial
- Meals
- Personal care items
- Pet care, other than for service animals
- Phone service and long-distance calls

- Reimbursement for mileage rewards or frequent flier coupons
- Reimbursement for travel before contacting us and receiving prior authorization
- Travel for medical procedures not listed above
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network or that have not been designated by Premera to perform the services
- Travel insurance

Mental Health Care

Benefits for mental health services to manage or lessen the effects of a psychiatric condition are provided as stated below.

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

Covered mental health services are:

- Inpatient care
- Outpatient therapeutic visits. “Outpatient therapeutic visit” (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Current Procedural Terminology** manual, published by the American Medical Association. Outpatient therapeutic visits can include interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. See the ***Virtual Care*** benefit.
- Treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
- Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders.
- Applied behavioral analysis (ABA) therapy for members with one of the following:
  - Autistic disorder
  - Autism spectrum disorder
  - Asperger's disorder
  - Childhood disintegrative disorder
  - Pervasive developmental disorder
  - Rett's disorder

  Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all ABA services for a member may be managed by a BCBA or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques. ABA therapy must be provided by:
  - A licensed physician (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 health agency or behavioral health agency that is also state-certified to provide ABA therapy.
  - A Board-Certified Behavior Analyst (BCBA). This means a provider who is state-licensed if the State licenses behavior analysts (Washington does). If the state does not require a license, the provider must be certified by the Behavior Analyst Certification Board. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.

- A therapy assistant/behavioral technician/paraprofessional, when their services are supervised and billed by a licensed provider or a BCBA.

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

- Hospital
- State-Licensed Community Mental Health Agency
- Licensed physician (MD or DO)
- Licensed psychologist (PhD)
- A state hospital operated and maintained by the state of Washington for the care of the mentally ill
- Any other provider listed under the definition of "provider" (see the ***Definitions*** section in this booklet) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of 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.
- Washington state-licensed Behavioral Health Agency

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

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

For substance use disorder conditions treatment information, see the ***Substance Use Disorder*** benefit.

For prescription drug benefit information, see the ***Prescription Drug*** benefit.

The Mental Health Care benefit doesn't cover:

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

Neurodevelopmental (Habilitation) Therapy

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

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

Inpatient Care Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility that meets our clinical standards and will only be covered when services can't be done in a less intensive setting.

Outpatient Care Benefits for outpatient physical, speech, occupational, and massage therapy are subject to all of the following provisions:

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

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

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

This benefit doesn't cover:

- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care

Newborn Care

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

If the mother isn’t eligible to receive obstetrical care benefits under this plan, the newborn isn’t automatically covered for the first 3 weeks. For newborn enrollment information, see the ***Who Is Eligible For Coverage?*** and ***When Does Coverage Begin?*** sections.

Benefits are provided on the same basis as any other care, subject to the child's own cost shares, if any, and other provisions as specified in this plan. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

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

Professional Care

Benefits for services received in a provider’s office are subject to the terms of the ***Professional Visits And Services*** benefit. Well-baby exams in the provider's office are covered under the ***Preventive Care*** benefit. This benefit covers:

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

Note: Attending provider as used in this benefit means a provider such as a physician (MD or DO), a physician’s assistant, a certified nurse midwife (CNM), a licensed midwife or an advanced registered nurse practitioner (ARNP).

This benefit doesn’t cover immunizations and outpatient well-baby exams. See the ***Preventive Care*** benefit for coverage of immunizations and outpatient well-baby exams.

Orthognathic Surgery (Jaw Augmentation Or Reduction)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) are provided. Covered orthognathic surgery for repair of congenital (apparent at birth) deformities determined to be medically necessary will not apply to any annual maximum or lifetime limits of this plan. These procedures are not covered under other benefits of this plan.

Prescription Drug

What's Covered

This benefit only covers drugs that are approved by the US Food and Drug Administration (FDA) that you get from a licensed pharmacy for take-home use. Covered drugs include the drugs and items listed below. All drugs and other items must be medically necessary.

Diabetic Drugs

Shots You Give Yourself

- Prescribed drugs for shots that you give yourself, such as insulin
- Needles, syringes, alcohol swabs, test strips, testing agents and lancets.

Nicotine Habit-Breaking Drugs Prescription brand and generic drugs to help you break a nicotine habit. Generic over-the-counter drugs are also covered.

Oral Chemotherapy This benefit covers drugs you can 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.

Glucagon and Allergy Emergency Kits

Prescription Vitamins

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. It is not covered under other benefits of this plan.

Specialty drugs These drugs treat complex or rare health problems. An example is rheumatoid arthritis. Specialty drugs also need special handling, storage, administration or patient monitoring. They are high cost and can be shots you give yourself.

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 the state and federal law. See ***Prescription Drug*** in the ***Summary Of Your Costs***. You must buy over-the-counter supplies and devices at the pharmacy counter. For details on how to submit a claim, see the ***How Do I File a Claim?*** section. For shots or devices from your provider, see ***Preventive Care***.

PV Core Plus Preventive Drugs The plan also covers some other preventive drugs. These drugs are on our PV Core Plus list. These drugs are effective in controlling health problems such as heart disease.

Please call customer service or log in to the member portal on our website to find out if a drug is on the PV Core Plus list. The phone number and our Web address are on the back of this booklet.

Preventive Drugs Required By The Affordable Care Act that your provider prescribes. 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 drugs are not covered in full and you may have to pay more out-of-pocket costs.

Off-Label Uses The US 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. The plan covers such drugs if the use is recognized as effective in standard drug reference guides put out by the American Hospital Formulary Service, the American Medical Association, the US Pharmacopoeia, or other reference guides also recognized by the Federal Secretary of the US Health and Human Services department or the Insurance Commissioner.

Drug uses that are not recognized by one of the above standard drug reference guides can be covered if they are recognized by the Secretary of the US Health and Human Services department or by the majority of relevant, peer-reviewed medical literature. For more details, see the definition of "prescription drug" in the ***Definitions*** section of this booklet.

Compound Medications To be covered, these must contain at least one covered prescription drug

Fertility Drugs Drugs for fertility treatment or assisted reproduction procedures. The limitations of the Assisted Reproduction benefit apply.

GETTING PRESCRIPTIONS FILLED
It is always a good idea to show your Premera Blue Cross ID card when you go to the pharmacy.

See question 6 of ***Questions And Answers About Your Pharmacy Benefits*** for exceptions to the supply limits shown in this table.

Pharmacy	Supply Limit	Instructions
In-Network Retail Pharmacies	100 days	Pay the cost share in the ***Summary Of Your Costs*** at the pharmacy
In-Network Specialty Pharmacies	30 days	Pay the cost share in the ***Summary Of Your Costs*** at the pharmacy
Out-Of-Network Retail Pharmacies	100 days	• Pay the full cost of the drug at the pharmacy. • Send Premera a claim. See ***How Do I File A Claim?*** in this booklet for instructions.
In-Network Mail-Order Pharmacy (Out-of-network mail-order pharmacies are not covered)	100 days	• Allow 2 weeks for your prescription to be filled. • Ask your provider to prescribe up to a 100-day supply of the drug you need. • Send your prescriptions and a pharmacy mail-order form to the mail-order pharmacy. You can download the form from our website or call us for a copy. Our website and phone numbers are on the back cover of this booklet.

Exclusions

This benefit does not cover:

- Over-the-counter drugs and supplies, even if you have a prescription, that are not listed as covered above. For example, the plan does not cover vitamins, food and dietary supplements (such as baby formula or protein powder), or herbal or naturopathic medicines.
- Drugs used to improve your looks, such as drugs to increase hair growth
- Drugs for experimental or investigational use. (See ***Definitions***.)
- Blood or blood derivatives. See the ***Blood Products And Services*** benefit for coverage.
- 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 are in a health care facility or provider’s office, or take-home drugs dispensed and billed by a health care facility.
- Replacement of lost or stolen items
- Solutions and drugs that you get through a shot or through an intravenous needle, a catheter or a feeding tube. See the ***Infusion Therapy*** benefit.
- Drugs to treat sexual dysfunction
- Drugs to manage your weight
- Medical equipment and supplies. See the ***Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies*** benefit for coverage.
- Immunization agents and vaccines.

Questions and Answers About Your Pharmacy Benefits

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

   This plan does make use of a list of drugs, sometimes referred to as a “formulary.”

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

This plan does cover non-preferred brand name drugs, but at a higher cost to you. However, this plan doesn't cover certain categories of drugs. These are listed under ***Exclusions*** earlier in this benefit.

Certain drugs need prior authorization. See ***Prior Authorization*** for more detail.

Generic Drug Substitution

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. If your prescriber does not want to substitute a generic for the brand name drug, you pay only the brand name cost share. See the ***Summary Of Your Costs*** for the amount you pay. However, if the prescriber allows you to take a generic drug instead, and you buy the brand name drug anyway, you will have to pay the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost share. Please ask your pharmacist about the higher cost you will pay if you select a brand name drug.

A "generic drug" is a prescription drug manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration (FDA). The FDA considers them to be therapeutically equivalent to the brand name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

This benefit also covers "biological products." Examples are serums and antitoxins. Generic substitution does not apply to biological products.

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

Our Pharmacy and Therapeutics Committee reviews the pharmacy drug list frequently throughout the year. It may make changes to the list at any point if new drugs appear on the market or new medical studies or other clinical information warrant the change.

If you're taking a drug that's changed from preferred to non-preferred status, we'll notify you before the change. The amount you pay is based on whether the drug is a generic, preferred or non-preferred drug on the date it is dispensed. Whether the pharmacy is in the network or not on the date the drug is dispensed is also a factor.

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

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can only be changed at the sole discretion of the Group. The plan's rules about substitution of generic drugs are described above in question 1.

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

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

You will find the amounts you pay for covered drugs in the ***Summary Of Your Costs***.

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

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

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

You can find an in-network 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 ID card.

Specialty drugs are covered only when you get them from specialty pharmacies. Specialty pharmacies are pharmacies that focus on the delivery and clinical management of specialty drugs. See the ***Summary Of Your Costs*** above for more information.

6. How many days' supply of most medications can I get without paying another copay or other repeating charge?

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the mail-order pharmacy benefit are described in the ***Getting Prescriptions Filled*** table above.

Benefits for refills will be provided only when the member has used 75% of a supply of a single medication. The 75% is calculated based on both of the following:

- The number of units and days' supply dispensed on the last refill
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill. This rule does not apply when a 12-month supply of contraceptive drugs has been dispensed in one fill or refill.

Exceptions to the supply limit are allowed:

- A pharmacist can approve an early refill of a prescription for eye drops or eye ointment in some cases. If you must pay a copay for the drug, the full copay is required for the early refill.
- A different supply can be allowed so that a new drug can be refilled at the same time as drugs that you are already taking. We will pro-rate the cost shares to the exact number of days early that the refill is dispensed.
- Up to a 12-month supply of contraceptive drugs can be dispensed on request. If you must pay a copay for the drug, you pay one copay for each 30-day supply from a retail pharmacy or one copay for each 90-day supply from the in-network mail-order pharmacy.

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

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

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

Preventive Care

This plan pays for preventive care as shown in the ***Summary Of Your Costs***. Below is a summary of preventive care services.

Preventive Exams

- Routine adult and well-child exams. Includes exams for school, sports and jobs
- Review of oral health for members under 19
- Vision screening for members under 19
- Depression screening

Immunizations

- Shots in a provider's office
- Flu shots, flu mist, whooping cough and other seasonal shots at a pharmacy or other community center
- Shots needed for foreign travel at the county health department or a travel clinic

Screening Tests

Routine lab tests and imaging, this includes women's preventive services as recommended by the HRSA women's preventive services guidelines and others such as:

- Mammograms (includes 3D mammograms)
- X-rays
- Pap smears

- Prostate-specific antigen tests
- BRCA genetic tests for members at risk for certain breast cancers.

Pregnant Member's Care

- Breastfeeding support and counseling
- Purchase of standard electric breast pumps
- Rental of hospital-grade breast pumps if medically necessary
- Screening for postpartum depression

Colorectal Cancer Screening

As often as recommended by your doctor. Includes:

- Barium enema
- Colonoscopy, sigmoidoscopy and fecal occult blood tests. The plan also covers a consultation before the colonoscopy and anesthesia your doctor thinks is medically necessary.
- If polyps are found during a screening procedure, removing them and lab tests on them are also covered as preventive.
- Colonoscopies as follow-up to positive non-invasive stool based screening tests.

Diabetes Screening

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 have our approval.

Nicotine Habit-Breaking Programs

Programs to stop smoking, chewing tobacco or taking snuff.

Nutritional Counseling and Therapy

Office visits to discuss a healthy diet and eating habits and help you manage weight. The plan covers screening and counseling for:

- Members at risk for health conditions that are affected by diet and nutrition
- Weight loss for children age 6 and older who are considered obese and for adults with a body mass index of 30 kg/meter squared or higher. This includes intensive behavioral interventions with more than one type of activity to help you set and achieve weight loss goals.

Fall Prevention

Risk assessments and advice on how to prevent falls for members who are age 65 or older and have a history of falling or have mobility issues

Pre-exposure (PrEP) for members at high risk for HIV infection.

Contraceptives

- Contraceptive devices, shots and implants. The plan will cover up to a 12-month supply of contraceptive pills. See ***Prescription Drug*** for coverage of prescription and over-the-counter drugs and devices.
- Emergency contraceptives ("plan B")
- Tubal ligation. When tubal ligation is done as a secondary procedure, only the charge for the procedure itself is covered under this benefit. The related services, such as anesthesia, are covered as part of the primary procedure. See ***Hospital*** and ***Surgery***.

About Preventive Care

Preventive care is a set of evidence-based services. These services are based on guidelines required under state or federal law. The guidelines come from:

- Services that the United States Preventive Services Task Force has given an A or B rating
- Immunizations that the Centers for Disease Control and Prevention recommends
- Screening and other care for women, babies, children and teens that the Health Resources and Services Administration recommends.
- Services that meet the standards in Washington state law.

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

The agencies above may also change their guidelines from time to time. If this happens, the plan will comply with the changes.

Some preventive services and tests have limits on how often you should get them. The limits are often based on your age or gender. For some services, the number of visits covered as preventive depends on your medical needs. 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.

Some of the covered services your provider does during a routine exam may not be preventive at all. The plan would cover them under other benefits. They would not be covered in full.

For example:

During your preventive exam, your provider may find a problem that needs further tests or screening for a proper diagnosis to be made. Or, if you have a chronic disease, your provider may check your condition with tests. These types of tests help to diagnose or monitor your illness and would not be covered under the ***Preventive Care*** benefit. You would have to pay the cost share under the plan benefit that covers the service or test.

The *Preventive Care* benefit does not cover:

- Take-home drugs or over-the-counter items. See ***Prescription Drug***.
- Routine newborn exams while the child is in the hospital after birth. See ***Newborn Care.***
- Routine or other dental care
- Services related to tubal ligation when it is done as a secondary procedure. The charge for the procedure itself is covered under this benefit, but the related services, such as anesthesia, are covered as part of the primary procedure. See the ***Hospital*** *and* ***Surgery*** benefits.
- Routine vision and hearing exams
- Gym fees or exercise classes or programs
- Services or tests for a specific illness, injury or set of symptoms. See the plan's other benefits.
- Physical exams for basic life or disability insurance
- Work-related disability or medical disability exams
- Purchase of hospital-grade breast pumps.
- Vasectomy. See ***Surgery***.

Professional Visits And Services

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

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

For surgical procedures performed in a surgical suite or other facility benefit information, see the ***Surgery*** benefit.

For professional diagnostic services benefit information, see the ***Diagnostic X-Ray, Lab, And Imaging*** benefit.

For home health or hospice care benefit information, see the ***Home Health Care*** and ***Hospice Care*** benefits.

For preventive or routine services, see the ***Preventive Care*** benefit.

For diagnosis and treatment of psychiatric conditions benefit information, see the ***Mental Health Care*** benefit.

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

Electronic Visits

This benefit will cover electronic visits (e-visits) from in-network providers when all the requirements below are met. This benefit is only provided when three things are true:

- Premera Blue Cross has approved the physician for e-visits. Not all physicians have agreed to or have the software capabilities to provide e-visits.
- The member has previously been treated in the approved physician's office and has established a patient-physician relationship with that physician.
- The e-visit is medically necessary for a covered illness or injury.

An e-visit is a structured, secure online consultation between the approved physician and the member. Each approved physician will determine which conditions and circumstances are appropriate for e-visits in their practice.

Please call Customer Service at the number shown on the back cover of this booklet for help in finding a physician approved to provide e-visits.

The *Professional Visits and Services* benefit doesn't cover:

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services

Psychological and Neuropsychological Testing

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

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

Rehabilitation Therapy

This plan covers rehabilitation therapy. Benefits must be provided by a licensed physical therapist, occupational therapist, speech language pathologist or a licensed qualified provider.

Rehabilitation therapy is therapy that helps get a part of the body back to normal health or function. It includes therapy to 1) restore or improve a function that was lost because of an accidental injury, illness or surgery; or 2) to treat disorders caused by a physical congenital anomaly.

Services provided for treatment of a mental health condition are provided under the ***Mental Health Care*** benefit.

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

Limits listed in the ***Summary Of Your Costs*** do not apply to rehabilitation related to treatment of cancer, such as for breast cancer rehabilitation therapy.

Inpatient Care

Inpatient rehabilitation care is covered when medically necessary and provided in a specialized inpatient rehabilitation center, which may be part of a hospital. If you are already an inpatient, this benefit will start when your care becomes mainly rehabilitative and you are transferred to an inpatient rehabilitation center. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary.

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

Outpatient Care

This benefit covers the following types of outpatient therapy:

- Physical, speech, hearing and occupational therapies. Physical, speech, and occupational assessments and evaluations related to rehabilitation are also covered.
- Cochlear implants
- Home medical equipment, medical supplies and devices

This benefit does not cover:

- Treatment that the ill, injured or impaired member does not actively take part in.
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary.
- Therapy for flat feet except to help you recover from surgery to correct flat feet.

Skilled Nursing Facility Care

This benefit includes:

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

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

This benefit does not cover:

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

Sleep Studies

This benefit covers medically necessary sleep studies to test for sleep apneas and for some sleep disorders that are not related to breathing problems.

This plan does not cover home sleep studies for members under 19.

Spinal and Other Manipulations

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

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

Substance Use Disorder

This benefit covers inpatient and outpatient substance use disorder conditions treatment and supporting services.

Covered services include services provided by a state-approved treatment program or other licensed or certified provider. Covered outpatient visits can include interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. See the ***Virtual Care*** benefit.

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

Note: Medically necessary detoxification is covered in any medically necessary setting. Detoxification in the hospital is covered under the ***Emergency Room*** and ***Hospital*** benefits. Acupuncture services when provided for substance use disorder conditions do not apply to the ***Acupuncture*** benefit visit limits.

The *Substance Use Disorder* benefit doesn't cover:

- Halfway houses, quarterway houses, recovery houses, and other sober living residences

Surgery

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

- Anesthesia or sedation and postoperative care as medically necessary.
- Cornea transplantation, skin grafts, repair of a dependent child's congenital anomaly, and the transfusion of blood or blood derivatives.
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services as described in the ***Preventive Care*** benefit.
- Surgery that is medically necessary to correct the cause of infertility. This does not include assisted reproduction techniques or sterilization reversal.
- Repair of a defect that is the direct result of an injury, providing such repair is started within 12 months of the date of the injury.
- Correction of functional disorders upon our review and approval.
- Vasectomy

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

For services to change gender, see the ***Gender Affirming Care*** benefit.

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

Surgical Center Care – Outpatient

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

Temporomandibular Joint Disorders (TMJ) Care

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

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

- Muscle pain linked with TMJ
- Headaches linked with the TMJ
- Arthritic problems linked with the TMJ

- Clicking or locking in the jawbone joint
- An abnormal range of motion or limited motion of the jawbone joint

This benefit covers:

- Exams
- Consultations
- Treatment

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

- X-rays. See ***Diagnostic X-Ray, Lab, and Imaging***.
- Surgery. See ***Surgery***.
- Hospital. See ***Hospital***.

Some surgeries need prior authorization before you get them. See ***Prior Authorization*** for details.

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

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

“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 the ***Definitions*** section, or primarily for cosmetic purposes

Therapeutic Injections

This benefit covers:

- 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

This benefit does not cover:

- Immunizations. See ***Preventive Care***.
- Self-injectable drugs. See ***Prescription Drug***.
- Infusion therapy. See ***Infusion Therapy***.
- Allergy shots. See ***Allergy Testing and Treatment***.

Transplants

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

Covered Transplants

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. See the ***Definitions*** section in this booklet for the definition of "experimental/investigational services." The plan reserves the right to base coverage on all of the following:

- Organ transplants and bone marrow/stem cell reinfusion procedures must meet the plan's criteria for coverage. The medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives are all reviewed.
- The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are:
  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney
  - Pancreas
  - Pancreas with kidney
  - Bone marrow (autologous and allogeneic)
  - Stem cell (autologous and allogeneic)

  Note: For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives other than bone marrow or stem cells. These procedures are covered on the same basis as any other covered surgical procedure. See the ***Surgery*** benefit.
- Your medical condition must meet the plan's written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An "approved transplant center" is a hospital or other provider that's developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and meets the other approval standards we use.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

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

Recipient Costs

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

Donor Costs

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

Travel And Lodging

Benefits are provided for certain travel expenses related to services provided by an approved transplant provider. See ***Medical Transportation*** for details.

The Transplants benefit doesn't cover:

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, that are not specifically stated under this benefit.

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for an organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services." See the ***Definitions*** section in this booklet.
- Personal care items
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future

Urgent Care

This benefit covers:

Exams and treatment of:

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

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

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

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

Virtual Care

Virtual care uses interactive audio and video technology or using store and forward technology in real-time communications between the member at the originating site and the provider for diagnoses, consultation, or treatment. Services must meet the following requirements:

- Covered services 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

This does not include services such as facsimile, email communication and SMS messages (texts) or services that are not HIPAA compliant and secured. See the ***Summary Of Your Costs*** for the types of virtual visits covered by this benefit.

Vision Care

Vision Exams

This benefit provides for routine vision exams by an ophthalmologist or optometrist as stated in the ***Summary Of Your Costs***. Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing

- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

The Vision Exam benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

Some clinics that are based in or owned by a hospital will charge a separate facility fee for all physician visits, including routine vision exams. Benefits for these fees will be subject to your calendar year deductible and coinsurance, if any.

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

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

Vision Hardware

Members 19 Or Older

Benefits for vision hardware for members 19 or older are provided when all of the requirements listed below are met:

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

The Vision Hardware benefit covers:

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

Vision hardware benefits are based on the "allowed amount" (see the ***Important Plan Information*** section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

This benefit will cover services and supplies (including hardware) received after your coverage under this benefit has ended when all of the following requirements are met:

- You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
- You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

For members 19 or older, the Vision Hardware benefit doesn't cover:

- Services or supplies that aren't named above as covered or that are covered under other provisions of this plan. See the ***Medical Vision Hardware*** subsection of the ***Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies*** benefit for hardware coverage for certain conditions of the eye.
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses

Members Under 19

The Vision Hardware benefit will provide coverage as shown in the ***Summary Of Your Costs*** until the end of the month in which the member turns 19.

Weight Management

Non-Surgical Weight Management

Benefits for non-surgical weight management are covered on the same basis as any other covered condition, subject to the applicable benefits, limitations and exclusions.

Non-Surgical Weight Management benefits include, but aren't limited to, coverage of the following outpatient medical services:

- Behavioral health visits
- Nutritional/dietician visits
- Physical therapy visits
- Physician visits
- Related lab and diagnostic services

For specific benefit information, see the ***Mental Health Care***, ***Preventive Care***, ***Rehabilitation Therapy***, ***Professional Visits And Services***, and ***Diagnostic X-Ray, Lab, and Imaging*** benefits.

Surgical Weight Loss Treatment (Bariatric Surgery)

Benefits for surgical treatment of morbid obesity are covered the same as any other covered condition subject to the criteria listed below, applicable benefits, limitations and exclusions.

Weight loss surgery requires prior authorization. See ***Prior Authorization*** in this booklet.

Coverage is available for bariatric procedures listed as medically necessary, when conservative measures have proven ineffective. Examples of conservative measures include but aren't limited to covered services under the Non-Surgical Weight Management benefit, diet and exercise programs.

To qualify for the surgical treatment for morbid obesity benefit, the member must meet the three criteria stated in the Claims Administrator's medical policy on bariatric surgery. A summary of these criteria is shown below. Please see the Bariatric Surgery medical policy at **www.Premera.com.** Click the link to Medical Policies at the bottom of the landing page.

The member must be diagnosed as one of the following:

- The member must be diagnosed as one of the following:
  - A body mass index (BMI) greater than 40 kg/m2; or
  - A BMI of 35 kg/m2 or more with at least ONE of the following conditions:
    - Established Coronary Heart Disease, such as:
      - History of angina pectoris (stable or unstable)
      - History of angioplasty
      - History of coronary artery surgery
      - History of myocardial infarction
    - Other Atherosclerotic Disease, such as:
      - Abdominal aortic aneurysm
      - Hypertension that is uncontrolled or resistant to treatment (medically refractory) with a blood pressure (BP) greater than 140/90 despite optimal medical management (attempted medical management must have included at least 2 medications of different classes).
      - Peripheral arterial disease
      - Symptomatic carotid artery disease
    - Type 2 Diabetes, uncontrolled by pharmacotherapy

    - Obstructive sleep apnea, as documented by a sleep study (polysomnography), that is uncontrolled by medical management (eg, CPAP or oral appliance).
- And participation in a physician administered weight reduction program lasting at least three continuous months (over a 90-day period of time) within the 12-month period before surgery is considered.
    - Evidence of active participation documented in the medical record includes:
        - Weight
        - Current dietary program (eg, MediFast, OptiFast)
        - Physical activity (eg, exercise/work-out program)
- Or documentation of participation in a structured weight reduction program such as Weight Watchers or Jenny Craig is an acceptable alternative if done in conjunction with physician supervision

You must also have a mental health evaluation and clearance by a licensed mental health provider to rule out any mental health disorders that would be a contraindication to bariatric surgery, rule out inability to provide informed consent, and rule out inability to comply with pre- and post-surgical requirements.

For specific surgical treatment benefit information, see the ***Hospital, Surgical Center Care-Outpatient*** and ***Surgery*** benefits.

The Weight Management benefit does not cover:

- Procedures or treatments that are experimental and investigational (see the ***Definitions*** section in this booklet)
- Liposuction or surgical removal of excess skin unless medically necessary
- Over-the-counter medications for weight loss
- Liquid diet or fasting programs
- Other food replacement and nutritional supplements
- Membership in diet programs
- Exercise programs and health clubs
- Wiring of the jaw
- Weight management drugs

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

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association (“BCBSA”), Premera Blue Cross has arrangements with other Blue Cross and Blue Shield Licensees (“Host Blues”) for care in Clark County, Washington and outside Washington and Alaska. These arrangements are called “Inter-Plan Arrangements.” Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' in-network providers. The Host Blue is responsible for its in-network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (non-contracted providers). This Out-Of-Area Care section explains how the plan pays both types of providers.

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

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

BlueCard Program

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

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

Often, the allowed amount is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group

of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

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

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

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

Taxes, Surcharges and Fees

A law or regulation may require a surcharge, tax or other fee be added to the price of a covered service. If that happens, we will add that surcharge, tax or fee to the allowed amount for the claim.

Non-Contracted Providers

It could happen that you receive covered services from providers in Clark County, Washington and outside Washington and Alaska 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 ***Allowed Amount*** in ***Important Plan Information*** in this booklet for details on allowed amounts.

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

Blue Cross Blue Shield Global® Core

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the “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, please call our Customer Service Department. To find a provider, go to **www.premera.com** or call 800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

CARE MANAGEMENT

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

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment.

PRIOR AUTHORIZATION

You must get Premera's approval for some services before the service is performed. 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 For In-Network Cost shares For Out-Of-Network Providers** You 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 and out-of-area providers and facilities** will not request prior authorization for the service. You have to ask Premera to prior authorize the service.

  It is a good idea to ask Premera for prior authorization when you see a non-contracted provider. It is to your advantage to know ahead of time if the plan is not going to cover a service, equipment, or an inpatient stay.

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.

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

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

- A set number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis

- Certain drugs from certain pharmacies, or you may need to get a prescription drug from an appropriate medical specialist or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

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:

- Emergency services and emergency hospital admissions, including emergency drug or alcohol detox in a hospital.
- Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth.

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

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

Generally, non-emergent care by out-of-network providers is covered at a lower benefit level. However, you 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 are only available from an out-of-network provider. You or the out-of-network provider must ask for prior authorization before you receive the services.

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 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 at the in-network benefit level.

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 at the in-network benefit level without prior authorization for emergency services and hospital admissions for an emergency medical condition. 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 at the in-network benefit level. The plan will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital.

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

CLINICAL REVIEW

Premera Blue Cross has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. Our medical policies are on our website. You or your provider may review them at **www.premera.com**. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain the information, please send your request to Care Management at the address or fax number shown on the back cover.

Premera Blue Cross reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigational. A decision by Premera Blue Cross following this review may be appealed in the manner described in ***Complaints And Appeals***.

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

PERSONAL HEALTH SUPPORT PROGRAMS

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

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

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

EXCLUSIONS AND LIMITATIONS

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

Amounts Over The Allowed Amount

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

Benefits From Other Sources

Services that are covered by liability insurance, motor vehicle insurance, excess coverage, no fault coverage, or workers compensation or similar coverage for work-related conditions. For details, see ***Third Party Recovery*** under ***What If I Have Other 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 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 does not apply to services that are determined to be as medically necessary for Gender Affirming Care.

Counseling, Education or 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.

This exclusion also doesn't apply to dental services covered under the ***Temporomandibular Joint Disorders (TMJ) Care*** benefit.

EEG biofeedback or neurofeedback services

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental or Investigational Services

Experimental or investigational services or supplies including any complication 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 does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer

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 services. Examples are prisons, nursing homes, juvenile detention facilities.

Orthodontia

Orthodontic services, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

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.
- 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 include:

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

Serious Adverse Events And Never Events

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, a surgery on the wrong body part or a wrong surgery.

Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical

errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-Network providers may not bill members for these services and members are held harmless.

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 Centers 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 services, 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 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 such treatments.

Voluntary Support Groups

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

Weight Loss Drugs

Drugs or supplements for weight loss or weight control.

Work-Related Illness Or Injury

Any illness, condition or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see ***Third Party Recovery*** under ***What If I Have Other Coverage***.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

You also may be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a “coordination of benefits” feature to handle such situations. We'll coordinate the benefits of this plan with those of your other plans to make certain that, in each calendar year, the total payments from all medical plans aren't more than the total allowable medical expenses and the total payments from all dental plans aren't more than the total allowable dental expenses.

All of the benefits of this plan are subject to coordination of benefits. However, note that benefits provided under this plan for allowable dental expenses will be coordinated separately from allowable medical expenses.

If you have other coverage besides this plan, we recommend that you send your claims to the primary plan first. In that way, the proper coordinated benefits may be most quickly determined and paid.

Definitions Applicable To Coordination Of Benefits

To understand coordination of benefits, it's important to know the meanings of the following terms:

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under any of the medical plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under any of the dental plans involved. When a plan provides benefits in the form of services or supplies

rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. For the purposes of this plan, only those dental services to treat an injury to natural teeth will be considered an allowable dental expense.

- **Claim Determination Period** means a calendar year.
- **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.
- **Medical Plan** means all of the following health care coverages, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents
  - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation
  - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease
- **Dental Plan** means all of the following dental care coverages, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents

Each contract or other arrangement for coverage described above is a separate plan. It's also important to note that for the purpose of this plan, we'll coordinate benefits for allowable medical expenses separately from allowable dental expenses, as separate plans.

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the “primary” plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become “secondary.” This means they reduce their payment amounts so that the total benefits from all medical plans aren't more than the allowable medical expenses and the total benefits from all dental plans aren't more than the total allowable dental expenses. We will coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

Primary And Secondary Rules

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

A plan that doesn't have a COB provision that complies with 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. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

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

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

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

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

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

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

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

Length Of Coverage The plan that covered you longer is primary to the plan that didn't cover you as long. If we do not have your start date under the other plan, we will use the employee's hire date with the other group instead. We will compare that hire date to the date your coverage started under this plan to find out which plan covered you for the longest time.

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

Any amount by which a secondary plan's benefits have been reduced in accord with this section shall be used by the secondary plan to pay your allowable medical expenses or allowable dental expenses not otherwise paid, and such reduced amount shall be charged against the applicable plan's benefit limit (medical or dental). However, you must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for allowable medical expenses or allowable dental expenses based on all claims that were submitted up to that time during the claim determination period.

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

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 RECOVERY

General

If you become ill or are injured by the actions of a third party, your medical care should be paid by that third party. For example, if you are hurt in a car crash, the other driver or their insurance company may be required under law to pay for your medical care.

This plan does not pay for claims for which a third party is responsible. However, the plan may agree to advance benefits for your injury with the understanding that it will be repaid from any recovery received from the third party. By accepting plan benefits for the injury, you agree to comply with the terms and conditions of this section.

In addition, the plan maintains a right of subrogation, meaning the right of the plan to be substituted in place of the member who received benefits with respect to any lawful claim, demand, or right of action against any third party that may be liable for the injury, illness or medical condition that resulted in payment of plan benefits. The third party may not be the actual person who caused the injury and may include an insurer to which premiums have been paid.

The plan administrator has discretion to interpret and to apply the terms of this section. It has delegated such discretion to Premera Blue Cross and its affiliate to the extent we need in order to administer this section.

Definitions

The following definitions shall apply to this section:

Injury An injury or illness that a third party is or may be liable for.

Recovery All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgment, award, or settlement. It does not matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amounts put into a trust or constructive trust set up by or for you or your family, beneficiaries or estate as a result of your injury.

Reimbursement Amount The amount of benefits paid by the plan for your injury and that you must pay back to the plan out of any recovery per the terms of this section.

Responsible Third Party A third party that is or may be responsible under the law (“liable”) to pay you back for your injury.

Third Party A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers’ compensation coverage. The third party may not be the actual party who caused the injury, and may include an insurer.

Note: For this section, a third party does not include other health care plans that cover you.

You In this section, “you” includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

Benefits From Other Sources

Benefits are not available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage, or Medical Premises coverage

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

Work-Related Illness Or Injury

This plan does not cover 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 pay you for an illness or injury you get on the job.

  However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost sharing required by motor vehicle coverage, unless applicable state law requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits.

- The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer or your estate.
  - The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.
- The plan's right to reimbursement first and in full shall apply even if:
  - The recovery is not enough to make you whole for your injury.
  - The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
  - The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
  - The member is a minor, disabled person, or is not able to understand or make decisions.
  - The member did not make a claim for medical expenses as part of any claim or demand
- Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.

  The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third-party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

- If any of the requirements below are not met, the plan shall:
  - Deny or delay claims related to your injury
  - Recoup directly from you all benefits the plan has provided for your injury
  - Deduct the benefits owed from any future claims
- You must notify Premera Blue Cross of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information.

  Neither the plan nor Premera Blue Cross shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

  Claims for your injury shall not be paid until Premera Blue Cross receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

If you receive a recovery, you or your lawyer shall hold the Recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the plan's reimbursement rights have been determined, you shall make immediate payment to the plan out of the recovery proceeds.

If you or your lawyer do not promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to one or both of the following:

- Initiating an action against you and/or your lawyer to compel compliance with this section.
- Withholding plan benefits payable to you or your family until you and your lawyer complies or until the reimbursement amount has been fully paid to the plan.

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage.

SUBSCRIBER ELIGIBILITY

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

- Be a regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group's payroll system, and reported by the Group for Social Security purposes.
- Eligible for coverage the first of month following or coinciding with date of hire (if hired first business day of the month)

RETIREE ELIGIBILITY

Employees who retire from the Company and were considered active full-time employees working at least 20 hours per week at the time of retirement may continue coverage under this plan. Retired employees will be eligible for coverage if they meet all of the following criteria:

- The retiree has a minimum of 15 years of credited service and has been a full-time employee the entire duration.

- The retiree was an active full-time employee at the time of retirement.
- The retiree is between the ages of 55 to 64.
- The retiree is not covered by Medicare. If the retiree becomes covered under Medicare, the retiree's eligibility will be forfeited.

All coverage terminates as of the date of the 65th birthday of the eligible member. Benefits shall be paid at the same levels as those covered as active full-time employees; however, the retiree will be required to pay the full Plan costs during the eligible period. Benefits for a covered spouse of a retiree will terminate on the date the spouse reaches age 65. Upon termination, the spouse will be eligible to elect continuation coverage under the Plan's COBRA provisions. Benefits for a covered child of a retiree will terminate the first of the month following the date the child reaches age 26 or the date of the eligible retiree's 65th birthday, whichever is first. Upon termination, the child will be eligible to elect continuation of coverage under the Plan's COBRA provisions.

Employees Performing Employment Services In Hawaii

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

DEPENDENT ELIGIBILITY

A dependent is defined as an individual who is: (1) listed on the employee's application as a dependent of the employee; (2) eligible for dependent coverage (based upon the criteria above); (3) whose application has been accepted by the Plan Supervisor; and (4) for whom the applicable rate of coverage has been paid. Dependents eligible for coverage under this plan are:

- An employee's legally married spouse as defined in the definition section. Coverage may continue during a legal separation only if ordered by a court decree.
- A domestic partner. Domestic partners are defined as two adults, of the same or opposite sex, engaged in a spouse-like relationship and who are living together in the same residence. Employees will certify that they are either married or single with a domestic partner. Domestic partner certification must meet all of the following criteria:
  - They share the same regular and permanent residence.
  - They have a close, personal relationship.
  - They are jointly responsible for "basic living expenses" *, as defined below.
  - They are not married to anyone.
  - They are each eighteen (18) years of age or older.
  - They are not related by blood closer than would bar marriage in the State of Washington and Oregon or other States that Parametrix operates within.
  - They were mentally competent to consent to contract when their domestic partnership began.
  - They are each other's sole domestic partner and are responsible for each other's common welfare.

  Basic Living Expenses are defined as cost of basic food, shelter, and any other expenses of a Domestic Partner, which are paid at least in part by a program, or benefit for which the partner qualified because of the Domestic Partnership. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

  Coverage is available to the dependent children of one or both domestic partners provided that the children meet the requirements for an eligible dependent child below.
- An employee's dependent child(ren) under age 26.
- An employee's dependent child(ren) who is 26 or older incapable of self-support because of mental retardation, mental illness or physical incapacity that began prior to the date on which the child's eligibility would have terminated due to age. Proof of incapacity must be received within 30 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as is reasonably necessary to verify continued eligibility for benefits.

- An employee's dependent child(ren) whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support Order (QMCSO).
- Adopted children are eligible under the same terms and conditions that apply to dependent, natural children of parents covered under this Plan.
- Any individual who is covered as a dependent cannot also be covered as an employee.

If a husband and wife are both eligible for coverage under this plan as an employee, they must both be covered as an employee and cannot be dependents of the others coverage.

The term "dependent children" means any of the employee's natural children, legally adopted children, or children who have been placed for adoption with the employee prior to the age of 18, or step-children, or children who have been placed under the legal guardianship of the employee or the employee's spouse by a court decree or placement by a State agency.

RETIREE ELIGIBILITY

Employees who retire from the Company and were considered active full-time employees working at least 30 hours per week at the time of retirement may continue coverage under this plan. Retired employees will be eligible for coverage if they meet all of the following criteria:

- The retiree has a minimum of 20 years of credited service and has been a full-time employee the entire duration.
- The retiree was an active full-time employee at the time of retirement.
- The retiree is between the ages of 55 to 64.
- The retiree is not covered by Medicare. If the retiree becomes covered under Medicare, the retiree's eligibility will be forfeited.

All coverage terminates as of the date of the 65th birthday of the eligible member. Benefits shall be paid at the same levels as those covered as active full-time employees; however, the retiree will be required to pay the full Plan costs during the eligible period. Benefits for a covered spouse of a retiree will terminate on the date the spouse reaches age 65. Upon termination, the spouse will be eligible to elect continuation coverage under the Plan's COBRA provisions.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

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

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

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

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

Dependents Through Marriage After The Subscriber's Effective Date

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

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

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To extend the child's coverage beyond the 3-week period, the subscriber

should follow the steps below. If the mother isn't eligible for obstetrical care benefits, but the child qualifies as an eligible dependent, the subscriber should follow the steps below to enroll the child from birth.

- An enrollment application isn't required for natural newborn children when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for natural newborn children on the date of birth.
- When subscription charges being paid don't already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us within 60 days following birth. Coverage becomes effective from the date of birth. If we don't receive the enrollment application within 60 days of birth, see the ***Open Enrollment*** provision later in this section.

Adoptive Children On Or After The Subscriber's Effective Date

- An enrollment application isn't required for adoptive children placed with the subscriber when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for adoptive children on the date of placement with the subscriber.
- When subscription charges being paid don't already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us within 60 days following the date of placement with the subscriber. Coverage becomes effective from the date of placement. If we don't receive the enrollment application within 60 days of the date of placement with the subscriber, see the ***Open Enrollment*** provision later in this section.

Foster Children

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

Children Through Legal Guardianship

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

Children Covered Under Medical Child Support Orders

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

SPECIAL ENROLLMENT

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

Involuntary Loss of Other Coverage

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

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

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

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

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

Subscriber And Dependent Special Enrollment

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

State Medical Assistance and Children's Health Insurance Program

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

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

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

OPEN ENROLLMENT

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

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

CHANGES IN COVERAGE

The Group may change its terms, benefits and limitations at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

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

PLAN TRANSFERS

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

When you transfer from the Group's other plan, and there's no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied under the prior plan:

- Benefit maximums
- Out-of-pocket maximum
- Calendar year deductible. **Note:** This plan applies only expenses incurred in the current calendar year to the current year's calendar year deductible. So, we will credit expenses that were applied to your prior plan's calendar year deductible **only** when they were incurred during the current calendar year. We won't credit toward this plan's calendar year deductible expenses incurred during October through December of the prior year.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when:
  - The next required monthly charge for coverage isn't paid when due or within the grace period
  - The subscriber dies or is otherwise no longer eligible as a subscriber
- For a spouse when their marriage to the subscriber is annulled, or when they become legally separated or divorced from the subscriber
- For a child when they cannot meet the requirements for dependent coverage shown under the ***Who Is Eligible For Coverage?*** section.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

The Group is not required to keep the plan in force for any length of time. The Group reserves the right to change or terminate this plan, in whole or in part, at any time with no liability. Plan changes are made as described in ***Changes In Coverage*** in this booklet. If the plan were to be terminated, you would only have a right to benefits for covered care you receive before the plan's end date.

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age (shown under ***Dependent Eligibility***) for a dependent child who can't support 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 subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes the Group with a Request for Certification of Disabled Dependent form. The Group 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 requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

LEAVE OF ABSENCE

Family and Medical Leave Act

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

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

The subscriber must pay their normal share of the subscription charges during the leave.

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

If the subscriber does not return to work at the end of the FMLA leave, the subscriber and covered family members will have a right to elect COBRA coverage. The FMLA leave period does not count as part of the COBRA period.

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

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

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

Other Leaves of Absence

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

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

LABOR DISPUTE

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

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

COBRA

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

The plan will provide qualified members with COBRA coverage when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the “plan administrator” within COBRA's time limits.

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

Qualifying Events And Length Of Coverage

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

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

The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:

- **The subscriber's work hours are reduced.**
- **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

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

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

The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:

- **The subscriber dies.**
- **The subscriber and spouse legally separate or divorce.**
- **The subscriber becomes entitled to Medicare.**
- **A child loses eligibility for dependent coverage.**

  In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.
- The **Group must offer the retired subscriber and covered dependents an election to continue their retiree coverage if that coverage is lost because the Group filed for bankruptcy.** COBRA also considers coverage to have been lost due to this qualifying event if the retiree group coverage was substantially

eliminated at any time between 1 year before the bankruptcy proceeding commenced and 1 year after it commenced.

Under this qualifying event, the retired subscriber may continue coverage for up to the rest of his or her life. The retired subscriber's covered spouse and children may continue for up to 36 months after the retired subscriber's death or until they lose eligibility as dependents, whichever occurs first. (If the retired subscriber died before the bankruptcy, but his or her spouse is still covered under this plan when the bankruptcy filing occurred, that surviving spouse may continue coverage for up to the rest of his or her life.)

- **The Group must offer the retired subscriber and covered dependents an election to continue their retiree coverage if that coverage is lost because the Group filed for bankruptcy.** COBRA also considers coverage to have been lost due to this qualifying event if the retiree group coverage was substantially eliminated at any time between 1 year before the bankruptcy proceeding commenced and 1 year after it commenced.
- Under this qualifying event, the retired subscriber may continue coverage for up to the rest of his or her life. The retired subscriber's covered spouse and children may continue for up to 36 months after the retired subscriber's death or until they lose eligibility as dependents, whichever occurs first. (If the retired subscriber died before the bankruptcy, but his or her spouse is still covered under this plan when the bankruptcy filing occurred, that surviving spouse may continue coverage for up to the rest of his or her life.)

Conditions Of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

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

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

  Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See ***When COBRA Coverage Ends***.
- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

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

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

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

You Must Enroll And Pay On Time

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

  Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.
- You must send your first payment to the Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly payments must also be paid to the Group.

Adding Family Members

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

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

COBRA coverage will end on the last day for which any charge required for it has been paid in the monthly period in which the first of the following occurs:

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

  (This doesn't apply to retirees and their dependents who are continuing retiree coverage as a result of a bankruptcy filing.)
- The Group ceases to offer group health care coverage to any employee.

If You Have Questions

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

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than as described under ***Intentionally False Or Misleading Statements***.

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

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

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

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

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

CONTINUATION UNDER USERRA

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

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

MEDICARE SUPPLEMENT COVERAGE

If you're enrolled in Parts A and B of Medicare, you may be eligible for guaranteed-issue coverage under certain Medicare supplement plans. You must apply within 63 days of losing coverage under this plan.

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

Step 1

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

Step 2

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

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

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

Prescription Drug Claims

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

In-Network Pharmacies

For retail pharmacy purchases, you don't have to send us a claim. Just show your Premera Blue Cross ID card to the pharmacist, who will bill us directly. If you don't show your ID card, you'll have to pay the full cost of the prescription and submit the claim yourself for reimbursement. The reimbursement is based on the allowed amount.

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

Out-Of-Network Pharmacies

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

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

TIMELY FILING

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies

- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

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

SPECIAL NOTICE ABOUT CLAIMS PROCEDURE

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

- If your claim was denied, in whole or in part, our written notice (see ***Notices***) will include:
- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information needed to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of the plan's complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter stating these reasons.

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

If all you have to pay is a copay for a covered service or supply, 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. The phone number is on the back cover of your booklet and on your Premera ID card. Or, you can visit our website for secure online access to your claims. If your claim is denied in whole or in part, you may send us a complaint or appeal as outlined under ***Complaints And Appeals***.

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

COMPLAINTS AND APPEALS

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

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

What is a Complaint?

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

How to file a Complaint

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

Call customer service at 800-722-1471 (TTY:711)

Send a fax to 425-918-5592

Send the details in writing to:

Premera Blue Cross
PO Box 91102
Seattle, WA 98111-9202

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 protection 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.

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.
Level 2 (Internal)	If we deny your Level 1 appeal you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified or our Level 1 appeal decision.
External	If we deny your Level 2 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	Four months from the date you were notified of our Level 2 appeal decision. OR Four months 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 appeals process, call customer service at 800-722-1471 (TTY:711)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **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: Appeal Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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 91102
Seattle, WA 98111

Fax: 425-918-5592

Appeal Response Time Limits

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

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 15 days
All other appeals	15-30 days
External appeals	• Urgent appeals within 72 hours • Other IRO appeals within 45 days after the IRO gets the information

IF WE NEED MORE TIME

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

WHAT IF YOU HAVE ONGOING CARE

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

If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, the plan 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 the plan paid for ongoing care during the appeal review

WHAT HAPPENS IF IT'S URGENT

If your condition is urgent, you will get our response sooner. 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: Appeal Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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

External appeals are also 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 on behalf of the plan.

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.

You can also contact the Employee Benefits Security Administration of the U.S. Department of Labor. The phone number is 866-444-EBSA (3272).

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how this plan is administered. It also includes information about federal and state requirements we and the Group must follow and other information that must be provided.

Conformity With The Law

If any provision of the plan or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Evidence Of Medical Necessity

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

Healthcare Providers — Independent Contractors

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

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, the plan is entitled to recover these amounts. See the ***Right Of Recovery*** provision later in this section.

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

- 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)

Please Note: we cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Member Cooperation

You're under a duty to cooperate with us and the Group in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and the Group 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 as applicable.)

Notice Of Information Use And Disclosure

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

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

- Underwriting and determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.)
- Coordinating benefits with other health care plans
- Conducting care management or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with the Group

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 the plan provides 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 group or individual insurance plans that cover you

Notices

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if it's mailed to the Group or subscriber at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you are required to submit notice to us, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

Right Of Recovery

On behalf of the plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is 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 wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, the plan 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, we have the right to direct 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 the plan's obligation as to payment of benefits.

Venue

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

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

All suits or legal or arbitration proceedings brought by the plan will be filed within the appropriate statutory period of limitation, and you agree that venue, at the plan's 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***.

WHAT ARE MY RIGHTS UNDER ERISA?

This plan is an employee welfare benefit plan that's subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the “ERISA Plan” in this section.

When used in this section, the term “ERISA Plan” refers to the Group's employee welfare benefit plan. The “ERISA Plan administrator” is the Group or an administrator named by the Group. Premera Blue Cross is **not** the ERISA plan administrator.

As participants in an employee welfare benefit plan, subscribers have certain rights and protections. This section of this plan explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. (The Group has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in the plan to the extent stated in our administrative services contract with the Group). No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA

Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either the:

- Office of the Employee Benefits Security Administration, U.S. Department of Labor, 300 Fifth Ave., Suite 1110, Seattle, WA 98104; or
- Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan.

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 protection 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.

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
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
  - The United States Department of Defense
  - The United States Department of Veterans' Affairs
  - A nongovernmental research entity abiding by current National Institute of Health guidelines

Community Mental Health Agency

An agency that's licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.

Complication of Pregnancy

A medical condition related to pregnancy or childbirth that falls into one of these three categories:

- A condition of the fetus that needs surgery while still in the womb (in utero)
- A condition the mother has that is caused by the pregnancy. It is more difficult to treat because of the pregnancy. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix that requires treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma, such as uterine rupture before onset or during labor
  - Hemorrhage before or after delivery that requires medical or surgical treatment

- Placental conditions that require surgical intervention
- Preterm labor and monitoring
- Toxemia
- Gestational diabetes
- Hyperemesis gravidarum
- Spontaneous miscarriage or missed abortion
- A disease the mother has during pregnancy that is not caused by the pregnancy. The disease is made worse by pregnancy

- A complication of pregnancy needs services that are more than the usual maternity services. This includes care before, during, and after birth (normal or cesarean).

Congenital Anomaly

A marked difference from the normal structure of an infant's body part that's present from birth.

Cosmetic Services

Services that are performed to reshape normal structure of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

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 portion of a service, procedure or supply that is provided primarily:

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Detoxification

Active medical management of medical conditions due to 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)

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of their state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Chiropractor (DC)
- Dentist (DDS or DMD)
- Optometrist (OD)
- Podiatrist (DPM)

- Psychologist
- Nurse (RN and ARNP) licensed in Washington state

Donor Human Milk

Human milk that has been contributed to a milk bank by one or more donors.

Effective Date

The date when your coverage under this plan begins.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the Group's health care plan. If a subscriber or dependent enrolls under the ***Special Enrollment*** provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

Emergency 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.

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 disorder 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.
- 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.

Group

The entity that sponsors this self-funded plan.

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.

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, 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.

In-Network Provider

A provider that is in one of the networks stated in the ***How Providers Affect Your Costs*** section.

Inpatient

Confined in a medical facility as an overnight bed patient.

Lifetime Maximum

The maximum amount that your insurance benefit 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 70.38.025, 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 time during pregnancy and within 45 days following delivery.

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 terms of 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 health care 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” and “Your”)

A person covered under this plan as a subscriber or dependent.

Mental Health 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.

Milk Bank

An organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.

Non-Contracted Provider

A provider is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

Non-Participating Provider

A provider that is not in one of the provider networks stated in the ***How Providers Affect Your Costs*** section 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.

Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Out-Of-Network Provider

A provider that is not in one of the provider networks stated in the ***How Providers Affect Your Costs*** section.

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 Drug*** benefit under this plan.

Plan

The Group's self-funded plan described in this booklet.

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)

- The Federal Secretary of Health and Human Services

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

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

Prior Authorization

Prior authorization is a process that requires you or a provider to follow before a service is given, to determine if 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 health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of their employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

Board Certified Behavior Analysts (BCBAs) will be considered health care providers for the purposes of providing applied behavior analysis (ABA) therapy, as long as both of the following are true: 1) They’re licensed when required by the State in which they practice, or, if the State does not license behavior analysts, are certified as such by the Behavior Analyst Certification Board, and 2) The services they furnish are consistent with state law and the scope of their license or board certification. Therapy assistants/behavioral technicians/paraprofessionals that do not meet the requirements above will also be covered providers under this plan when they provide ABA therapy and their services are supervised and billed by a BCBA or one of the following state-licensed provider types: psychiatrist, developmental pediatrician, pediatric neurologist, psychiatric nurse practitioner, advanced nurse practitioner, advanced registered nurse practitioner, occupational or speech therapist, psychologist, community mental health agency that is also state-certified to provide ABA therapy.

Psychiatric Condition

A condition listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse.

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

Rehabilitation services include physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or 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.

Services

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

Service Area

The area in which we directly operate provider networks. This area is made up of the states of Washington (except Clark County) and Alaska

Skilled 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 providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Spouse

Someone who is legally married to the subscriber. A spouse can also be the subscriber’s domestic partner.

Subscriber

An enrolled employee of the Group. Coverage under this plan is established in the subscriber's name.

Subscription Charges

The monthly rates to be paid by the member that are set by the Group as a condition of the member's coverage under the plan.

Substance Use Disorder Conditions

They are 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 providers 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.

We, Us and Our

Premera Blue Cross.

Where To Send Claims

MAIL YOUR CLAIMS TO

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
ATTN: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Manager At

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

Customer Service

Mailing Address

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

Physical Address

6707 220th St. SW
Mountlake Terrace, WA 98043

Phone Numbers

Local and toll-free number:
800-722-1471

Local and toll-free TTY number:
711

Care Management

Prior Authorization And Emergency Notification

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

Local and toll-free number:
800-722-1471
Fax: 800-843-1114

Complaints And Appeals

Premera Blue Cross
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111-9202
Fax: (425) 918-5592

BlueCard

800-810-BLUE(2583)

Website

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