School Employees Benefits Board (SEBB) Program

Peak Care EPO

4018486

PREMERA | BLUE CROSS

INTRODUCTION

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association. The benefits, limitations, exclusions and other coverage provisions in this booklet are subject to the terms of our contract with the Group. This booklet is a part of that contract, which is on file in the Group's office and at Premera Blue Cross. This booklet replaces any other benefit booklet you may have received. The Group has delegated authority to Premera Blue Cross to use its expertise and judgment as part of the routine operation of the plan to reasonably apply the terms of the contract for making decisions as they apply to benefits and claims situations. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal, have independent review of our judgment and decisions, or bring a civil lawsuit challenging to any eligibility or claims determinations under the contract, including our exercise of our judgment and expertise.

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see *Definitions*). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including changes which become effective on the beginning of the calendar year, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

Group Name:	Washington State Healthcare Authority For The School Employees Benefits Board Program
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Group Number:	4018486
Plan:	Peak Care EPO
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PREMERA BLUE CROSS

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, 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, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TRS: 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-807-7310 (TRS: 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 800-807-7310（TRS：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-807-7310 (TRS: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-807-7310 (TRS: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-807-7310 (служба коммутируемых сообщений: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-807-7310 (TRS: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-807-7310 (служба комутованих повідомлень: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-807-7310 (TRS: 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。800-807-7310（TRS: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 800-807-7310 (በስልክ ማገናኛ አገልግሎት: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-807-7310 (TRS: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-807-7310 (رقم خدمة ترحيل الاتصالات للصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-807-7310 (TRS: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-807-7310 (TRS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-807-7310 (TRS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-807-7310 (TRS: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-807-7310 (SRT : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-807-7310 (TRS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-807-7310 (TRS: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-807-7310 (TRS: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TRS: 711) 800-807-7310 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** — services that are either limited or not covered under this plan
- **Medical Plan Eligibility And Enrollment** – 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 in Washington.

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 Web site 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. Please 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.

- The **networks**. To help control the cost of your care, this plan uses Premera's Tahoma network in Washington. **You will need to use in-network providers in order for most of your care to be covered.** Emergency care is one exception. See the summary table for more exceptions. For more network details, see ***How Providers Affect Your Costs***.
- The **allowed amount**. This is the most this plan allows for a covered service. It is often lower than the provider's billed charge. Providers not in one of the plan's networks have the right to bill you for amounts over the allowed amount. 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.
- The **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. The deductible does not apply to most services that require a copay. Any exceptions are shown in the table.

  This plan has a different copay for office visits with specialists than with non-specialists. To find out which providers get which copays, see ***How Providers Affect Your Costs***.

	In-Network Providers
Non-specialist professional visit copay	$20
Specialist professional visit copay	$40

- The **deductible**. The total allowed amount you pay in each year 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	$750	Not applicable
Family deductible (not shown in the summary table)	$1,875	Not applicable

- **Coinsurance**. For some healthcare, you pay a percentage of the allowed amount, and the plan pays the rest. This booklet calls your percentage "coinsurance." Your coinsurance is shown in the summary table.
- The **out-of-pocket maximum** (not shown in the summary table). 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	$3,500	Not applicable
Family out-of-pocket maximum	$7,000	Not applicable

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

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

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 although you do not pay any deductible, copay or coinsurance for covered services, the provider can bill you for amounts over the allowed amount.

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Acupuncture calendar year visit limit: 12 visits	Deductible, then 25% coinsurance	Not covered
Allergy Testing And Treatment	Deductible, then 25% coinsurance	Not covered
Ambulance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Blood Products and Services	Deductible, then 25% coinsurance	Not covered
Cellular Immunotherapy And Gene Therapy	Covered as any other in-network service	Not covered
Chemotherapy and Radiation Therapy Professional and facility services	Deductible, then 25% coinsurance	Not covered
Clinical Trials Covers routine patient care during the trial	Covered as any other service	Not covered
Dental Care		
• **Dental Anesthesia** (up to age 19 when medically necessary)		
• Inpatient facility care	Deductible, then 25% coinsurance	Not covered
• Outpatient surgery center	Deductible, then 25% coinsurance	Not covered
• Anesthesiologist	Deductible, then 25% coinsurance	Not covered
• **Dental Injury**		
• Exams to determine treatment needed	$40 copay per visit, deductible waived	Not covered
• Treatment	Deductible, then 25% coinsurance	Not covered
Diagnostic X-Ray, Lab, And Imaging for medical conditions or symptoms Tests, lab, imaging and scans	Deductible, then 25% coinsurance	Not covered
Dialysis For permanent kidney failure. See the ***Dialysis*** benefit for details.		
• During Medicare's waiting period	Deductible, then 25% coinsurance	Not covered
• After Medicare's waiting period	No charge	Not covered

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
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.	$150 copay per visit, then deductible, then 25% coinsurance	$150 copay per visit, then deductible, then 25% coinsurance
• Professional services	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Foot Care such as trimming nails or corns, when medically necessary due to a medical condition		
• In an office or clinic	$20 or $40 copay per visit, deductible waived	Not covered
• All other settings	Deductible, then 25% coinsurance	Not covered
Hearing Care		
Hearing Exams Limit each calendar year:1 exam/test	No charge	Not covered
Hearing Hardware Limit of 1 instrument per ear every 5 years	No charge	No cost-shares
Home Based Chronic Care For members who have a number of chronic conditions and complex health needs. Covers evaluation and management by a team of medical providers in your place of residence. **Note: You may be charged for some services, such as x-rays, lab, and medical equipment and supplies.** See the plan's benefits for those services for details.	Deductible, then 25% coinsurance	Not covered
Home Health Care calendar year visit limit: None • Home visits • Prescription drugs billed by the home health agency	Deductible, then 25% coinsurance	Not covered
Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies • Sales tax for covered items • Foot orthotics and therapeutic shoes; calendar year limit: $300 except diabetes related	Deductible, then 25% coinsurance	Not covered

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
• Medical vision hardware		
Hospice Care Lifetime limit for terminal illness: 6 months Lifetime limit for non-terminal illness: none Inpatient stay limit: 30 days Home visits: Unlimited Respite care: 240 hours		
• Inpatient facility care	Deductible, then 25% coinsurance	Not covered
• Home and respite care	Deductible, then 25% coinsurance	Not covered
• Prescription drugs billed by the hospice	Deductible, then 25% coinsurance	Not covered
Hospital		
• **Inpatient Care**		
• Professional	Deductible, then 25% coinsurance	Not covered
• Facility	Deductible, then 25% coinsurance	Not covered
• **Outpatient Care**		
• Professional	Deductible, then 25% coinsurance	Not covered
• Facility	Deductible, then 25% coinsurance	Not covered
Infusion Therapy	Deductible, then 25% coinsurance	Not covered
Massage therapy calendar year limit: 12 visits	Deductible, then 25% coinsurance	Not covered
Mastectomy and Breast Reconstruction		
• Office and clinic visits	$20 or $40 copay per visit, deductible waived	Not covered
• Surgery and other professional services	Deductible, then 25% coinsurance	Not covered
• Inpatient facility care	Deductible, then 25% coinsurance	Not covered
Maternity Care Care during pregnancy, childbirth and after the baby is born. See the ***Preventive Care*** benefit for routine exams and tests during pregnancy. Abortion is also covered. Abortion is also covered.		
• Professional care	Deductible, then 25% coinsurance	Not covered
• Inpatient hospital, birthing centers and short-stay hospitals	Deductible, then 25% coinsurance	Not covered
Medical Foods includes phenylketonuria (PKU)	Deductible, then 25% coinsurance	Not covered

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		
• For Transplants: $7,500 overall limit, per transplants	Deductible, then 0% coinsurance	Not covered
• **For Cellular Immunotherapy and Gene Therapy**: $7,500 per episode of care		
• To/from designated provider	No charge	No cost-shares
• To other providers	Not covered	Not covered
Special criteria are required for travel benefits to be provided. Please see the benefit coverage for details.		
Mental Health Care		
• Office and clinic visits	$20 copay per visit, deductible waived	Not covered
• Other professional services	Deductible, then 25% coinsurance	Not covered
• Inpatient and residential facility care	Deductible, then 25% coinsurance	Not covered
• Outpatient facility care	Deductible, then 25% coinsurance	Not covered
Neurodevelopmental Therapy (Habilitation) 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	$40 copay per visit, deductible waived	Not covered
• Other outpatient services	Deductible, then 25% coinsurance	Not covered
• Inpatient care calendar year visit limit: 45 days	Deductible, then 25% coinsurance	Not covered
Newborn Care		
• Inpatient care	Deductible, then 25% coinsurance	Not covered
• Office and clinic visits	$20 or $40 copay per visit, deductible waived	Not covered
• Other outpatient services	Deductible, then 25% coinsurance	Not covered
Orthognathic Surgery (Jaw Augmentation Or Reduction) lifetime limit: None		
• Office and clinic visits	$20 or $40 copay per visit, deductible waived	Not covered
• Surgery and other professional care	Deductible, then 25% coinsurance	Not covered
• Outpatient surgery facility care	Deductible, then 25% coinsurance	Not covered
• Inpatient hospital care	Deductible, then 25% coinsurance	Not covered

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Prescription Drug Deductible Separate from medical deductible	**In-Network Pharmacy**	**Out-Of-Network Pharmacy**
• Generic drugs	Waived	Waived
• Individual deductible for brand-name and specialty drugs	$125	$125 (separate from in-network drug deductible)
• Family deductible for brand-name and specialty drugs	$312	$312 (separate from in-network drug deductible)
Covered Drugs*	**In-Network Retail Pharmacy**	**Out-Of-Network Retail Pharmacy**
• Preferred Generic drugs	$7 copay	$7 copay plus 40% coinsurance
• Preferred brand name drugs	$30 copay	$30 copay plus 40% coinsurance
• Non-preferred generic and brand name drugs	30% coinsurance	70% coinsurance
	In-Network Mail-Order Pharmacy	**Out-Of-Network Mail-Order Pharmacy**
• Preferred Generic drugs	$14 copay	Not covered
• Preferred brand name drugs	$60 copay	Not covered
• Non-preferred generic and brand name drugs	30% coinsurance	Not covered
**Your cost-shares for covered prescription insulin drugs will not exceed $100 per 30-day supply of the drug. The deductible does not apply. Cost-shares for covered prescription insulin drugs apply toward the deductible.*		
Specialty Drugs (per prescription or refill). You must use a specialty pharmacy for these drugs to be covered.	**In-Network Specialty Pharmacy**	**Out-Of-Network Specialty Pharmacy**
• Preferred specialty drugs	$50 copay	Not covered
• Non-preferred specialty drugs	30% coinsurance	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
• Oral chemotherapy drugs	No charge	No cost-shares

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
• Female birth control drugs, devices and supplies (prescription and over-the-counter). Includes emergency birth control.	No charge	Same as out-of-network retail
• Male birth control devices and supplies (prescription and over-the-counter)	No charge	Same as out-of-network retail
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	Not covered
• Immunizations in the doctor's office	No charge	Not covered
• 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
• Nicotine habit-breaking programs	No charge	Not covered
• Fall prevention for members 65 and older	No charge	Not covered
• Nutritional counseling and therapy	No charge	No cost-shares
• Pregnant women's care (includes breast-feeding support and post-partum depression screening)	No charge	No cost-shares
• Screening tests (includes mammograms, prostate and cervical cancer screening)	No charge	Not covered
• Colon cancer screening	No charge	Not covered
• Male and female birth control and sterilization. (Vasectomy covered as preventive only if done in a doctor's office under local anesthetic)	No charge	Not covered

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, including telemedicine	$20 or $40 copay per visit, deductible waived	Not covered
• Electronic visits (e-visits)	$20 or $40 copay per visit, deductible waived	Not covered
• Other professional services	Deductible, then 25% coinsurance	Not covered
Psychological and Neuropsychological Testing	Deductible, then 25% coinsurance	Not covered
Rehabilitation Therapy		
• Outpatient Care calendar year visit limit: 45 visits		
• Office and clinic visits	$40 copay per visit, deductible waived	Not covered
• Other outpatient services	Deductible, then 25% coinsurance	Not covered
• Inpatient Care calendar year day limit: 45 days	Deductible, then 25% coinsurance	Not covered
Skilled Nursing Facility Care calendar year calendar year day limit: None	Deductible, then 25% coinsurance	Not covered
Spinal and Other Manipulations calendar year visit limit: 12 visits	Deductible, then 25% coinsurance	Not covered
Substance Use Disorder		
• Office and clinic visits	$20 copay per visit, deductible waived	Not covered
• Other professional services	Deductible, then 25% coinsurance	Not covered
• Inpatient care and residential facility care	Deductible, then 25% coinsurance	Not covered
• Outpatient facility care	Deductible, then 25% coinsurance	Not covered
Surgery (includes professional services, anesthesia and blood transfusions) See the ***Hospital*** and ***Surgical Center Care - Outpatient*** benefits for facility charges.	Deductible, then 25% coinsurance	Not covered
Surgical Center Care – Outpatient	Deductible, then 25% coinsurance	Not covered
Temporomandibular Joint Disorders (TMJ) Care		
• Office and clinic visits	$20 or $40 copay per visit, deductible waived	Not covered
• Other professional services	Deductible, then 25% coinsurance	Not covered

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
• Inpatient facility care	Deductible, then 25% coinsurance	Not covered
Therapeutic Injections	Deductible, then 25% coinsurance	Not covered
Transgender Services		
• Office and clinic visits	$20 or $40 copay per visit, deductible waived	Not covered
• Other professional services	Deductible, then 25% coinsurance	Not covered
• Inpatient facility care	Deductible, then 25% coinsurance	Not covered
Transplants (includes donor search and donation costs)		
• Inpatient facility care	Deductible, then 25% coinsurance	Not covered*
• Office and clinic visits	$20 or $40 copay per visit, deductible waived	Not covered*
• Surgery and other professional services	Deductible, then 25% coinsurance	Not covered*
**All approved transplant centers covered at the in-network level*		
*Please see **Medical Transportation** for travel and lodging benefits.*		
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	Deductible, then 25% coinsurance	Not covered
• Urgent care centers attached to or part of a hospital	$150 copay per visit, then deductible, then 25% coinsurance	$150 copay per visit, then deductible, then 25% coinsurance
Virtual Care – On Demand		
Access to medical care for low-level medical conditions using virtual methods like secure chat, text, voice or video chat.		
The same copay applies to both specialists and non-specialists.		
• General medical/dermatology	$5 copay, deductible waived	n/a
• Behavioral health	$20 copay, deductible waived	n/a
*See the **Professional Visits and Services**, **Mental Health Care** and **Substance Use Disorder** benefit for real-time visits with you and your*		

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
doctor via online and telephonic methods (telemedicine)		
Weight Management		
• Non-surgical weight management	As any other covered service	Not covered
• Surgical weight loss treatment (Bariatric Surgery)	Deductible, then 25% coinsurance	Not covered
*See the **Weight Management** benefit for additional benefit information.*		

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 covers care from in-network providers only. In-network providers are providers in the Tahoma network and pharmacies in the plan's pharmacy network.

This plan does not require use or selection of a primary care provider, or require referrals for specialty care. You may self-refer to in-network providers, including obstetricians, gynecologists and pediatricians, and you do not need prior authorization.

The plan gives you coverage for emergency care for a medical emergency anywhere in the world. This includes provider types that are covered under the plan but that are not in-network providers. **However, non-emergent care from an out-of-network provider is not covered.** There are a few exceptions, explained below and in specific benefits shown in the ***Summary Of Your Costs***.

See ***Definitions*** to find out about emergency care and medical emergencies.

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

In-Network providers provide medical care to members at negotiated fees. These fees are the allowed amounts for in-network providers. 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.

Your choice of a particular provider may affect your out-of-pocket costs because different providers may have different allowed amounts even though they all have an agreement with us or with the same Host Blue. You'll never have to pay more than your share of the allowed amount for covered services when you use in-network providers.

A list of in-network providers is in our Tahoma provider directory. You can access the directory at any time on our Web site at **www.premera.com/sebb**. 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. If you need emergency care outside Washington and Alaska or in Clark County, Washington, 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 Tahoma network.

Continuity Of Care

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

Continuity of care does not apply if your provider:

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

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

We will notify you immediately if the provider contract termination will happen within 30 days. Otherwise, we will notify you no later than 10 days after the provider's contract ends if we know that you are under an active treatment plan. If we learn that you are under an active treatment plan after your provider's contract ends, we will notify you no later than the 10th day after we become aware of this fact.

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

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

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

When continuity of care 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. Please see ***Complaints and Appeals***.

Out-Of-Network Providers

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

- Some providers in Washington that are not in the Tahoma network do have a contract with us. In cases where this plan does cover 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 has a contract with a Blue Cross and/or Blue Shield Licensee in Clark County Washington or outside Washington and Alaska.
- **Non-Contracted Providers** 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. You may also be required to submit the claim yourself. See ***How Do I File A Claim?*** for details.

Surprise Billing Protection

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

- **Emergency Care** from a non-contracted hospital in Washington, Oregon or Idaho or from a non-contracted provider that works at the hospital.
- The services below from a **non-contracted provider** at an **in-network hospital or outpatient surgery center in Washington**:
  - Surgery
  - Anesthesia
  - Pathology
  - Radiology
  - Laboratory
  - Hospitalist care

For the above services, you pay only the plan's in-network cost-shares, if any. See the ***Summary Of Your Costs***. Premera Blue Cross will work with the non-contracted provider to resolve any issues about the amount paid. Premera will also send the plan's payments to the provider directly. The provider must refund any amounts you have overpaid within 30 business days after the provider receives the payment.

Please note: The surprise billing protection does not apply to any other service from a non-contracted provider. If the service is not listed above, you must pay any amounts over the plan's allowed amount for the service. 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 Providers

The following covered services and supplies provided by out-of-network providers will always be covered:

- Emergency care for a medical emergency. (Please see the ***Definitions*** section for definitions of these terms.) This plan provides worldwide coverage for emergency care.

  The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is an in-network provider. Emergency care furnished by an out-of-network provider will be reimbursed at the in-network benefit level. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowed amount.
- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services named under ***Surprise Billing Protection*** earlier in the booklet.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Tahoma provider who doesn't have admitting privileges at a Tahoma hospital.

If a covered service is not available from an in-network provider, you may be able to receive benefits for services provided by an out-of-network provider. However, you 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. Your copay amounts are shown in the ***Summary Of Your Costs.***

SPLIT COPAY FOR OFFICE VISITS

This plan has two Professional Visit Copay amounts for in-network providers' office and home visits. When you see one of the types of in-network providers shown below, you pay the non-specialist copay shown in the ***Summary Of Your Costs*** for each office or home visit.

- Family practice physician
- General practice physician
- Internist
- Gynecologist
- Naturopath
- Advanced registered nurse practitioner (ARNP)
- Obstetrician
- Pediatrician
- Physician assistant
- Chiropractor
- Acupuncturist

For all other types of in-network providers covered by benefits subject to a professional visit copay, you pay the specialist copay shown in the ***Summary Of Your Costs*** for each visit.

Certain services 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 in-

network 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.

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 makes a payment for most covered services. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the allowed amount (please 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 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 your individual calendar year deductible 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

In addition to the individual deductible, we also keep track of the expenses applied to the family deductible which 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.

Please note: No enrolled family member will be required to satisfy more than the individual deductible amount.

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
- Copays
- The penalty for not asking for prior authorization when the plan requires it. See ***Prior Authorization*** in the ***Care Management*** section of this booklet.
- Your cost-shares for covered drugs purchased from out-of-network pharmacies.
- 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.

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. Please 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.

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

- Your coinsurance
- The calendar year deductibles

Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay any other cost-shares shown in ***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.

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
- The penalty for not requesting prior authorization when needed. See ***Prior Authorization*** in the ***Care Management*** section of this booklet.
- Your cost-shares for covered drugs purchased from out-of-network pharmacies.

In addition to the individual out-of-pocket maximum, we also keep track of the expenses applied to the family out-of-pocket maximum which 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.

Please note: In order to satisfy the in-network out-of-pocket amount, no enrolled family member has to pay more than the individual 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. The allowed amount is described below. There are different rules for emergency services. 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 the service area 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: 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.

  Non-Emergency Services Protected From Surprise Billing

  A different rule applies to certain services from a non-contracted provider at an in-network hospital or outpatient

surgery center in Washington. The services are surgery, anesthesia, pathology, radiology, laboratory, and hospitalist care. For these services, the allowed amount is the median in-network rate for the same or similar service in the same or similar geographic area.

Emergency Care

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 Tahoma 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

You do not have to pay amounts over the allowed amount for emergency care from non-contracted providers in Washington, Oregon, or Idaho.

If the non-contracted provider is not in Washington, Oregon or Idaho, you will be responsible for charges received from out-of-network providers above the allowed amount along with your deductible, copays and coinsurance.

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

If you have questions about this information, please call us at the number listed on your Premera 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 (please 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" (please see the ***Definitions*** section in this booklet) who's performing services within the scope of his or her license or certification.
- It must be furnished by an in-network provider, except as stated otherwise in ***How Providers Affect Your Costs*** or in specific benefits.
- 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/sebb** or by calling Customer Service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions throughout this section and the ***Exclusions*** 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

This benefit covers acupuncture to:

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

Please see the ***Summary of Your Costs*** for benefit limitations.

Allergy Testing and Treatment

This benefit covers:

- Testing
- Allergy shots
- Serums

Ambulance

This benefit covers:

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

These services are only covered when:

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

Air or sea emergency medical transportation is covered when:

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

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

Blood Products and Services

Benefits are provided for blood and blood derivatives.

Cellular Immunotherapy And Gene Therapy

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

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

Chemotherapy And Radiation Therapy

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs
- Dental extractions to prepare the jaw for radiation treatment

For chemotherapy drugs you get from a pharmacy, see ***Prescription Drug***. Some services need to be pre-approved 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 Care

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.

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

Diagnostic X-Ray, Lab And Imaging

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

For additional details see the following benefits:

- ***Preventive Care***
- ***Hospital***
- ***Emergency Room***

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

Dialysis

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

As soon as you are enrolled in Medicare Part B, Premera Blue Cross will pay your Medicare Part B premiums. Premera Blue Cross will continue to pay these premiums for as long as you are enrolled in this plan and eligible for Medicare due to ESRD.

Medicare has a waiting period, generally the first 90 days after dialysis starts. Benefits are different for dialysis during Medicare's waiting period than after the waiting period ends. Please see the ***Summary Of Your Costs***.

See ***How Providers Affect Your Costs*** for information about when out-of-network providers are covered.

Emergency Room

This benefit covers:

- Emergency room and doctor services
- Equipment, supplies and drugs used in the emergency room
- Services and exams used for stabilizing an emergency medical condition
- Diagnostic tests performed with other emergency services
- Medically necessary detoxification

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

You may need to pay charges over the allowed amount if you get care from a provider not in your network. See ***How Providers Affect Your Costs*** for details.

Foot Care

This benefit covers:

- Medically necessary foot care
- Treatment of corns and calluses
- Treatment of certain toenail conditions

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 tests
- 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 (M.D. or D.O.) 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
- The hearing aid instruments
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty, when provided by the manufacturer
- A follow-up consultation within 30 days following delivery of the hearing aids with either the prescribing physician or audiologist
- Repairs, servicing, and alteration of hearing aid equipment purchased under this benefit

This benefit 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.

Home-Based Chronic Care

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

You may be charged for items such as x-rays, lab tests, medical equipment and supplies. See the ***Summary Of Your Costs***, the ***Diagnostic X-Ray, Lab And Imaging*** and ***Medical Equipment And Supply*** benefits for details.

Home Health Care

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

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

This benefit covers:

- 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 home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

This benefit does not cover:

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

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 to correct vision due to medical eye conditions such as:

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

- Congenital cataract
- Corneal abrasion
- Keratoconus
- Progressive high (degenerative) myopia
- Irregular astigmatism
- Aniridia

External Prosthetics and Orthotic Devices used to:

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

Orthopedic Shoes and Shoe Inserts

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

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

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs. These services are covered under ***Prescription 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 (M.D. or D.O.).

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 person with a master's degree in social work.

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.
- End of life counseling provided by the hospice agency. For end of life counseling provided by any other providers, please see the ***Mental Health*** benefit.

Covered services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above.
- **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, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services

For additional information regarding hospice care, please call Customer Service at the number shown on the back cover of this booklet.

Hospital

This benefit covers:

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

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

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

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

This benefit does not cover:

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

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

Massage Therapy

Benefits are provided for medically necessary massage therapy received to treat a covered illness, injury or condition. Benefits must be from a licensed or certified provider performing within the scope of his or her license or certification, as allowed by law. Please see the ***Summary Of Your Costs*** for benefit limit information.

See the ***Rehabilitation Therapy*** benefit for information on coverage of physical and other rehabilitation therapies.

Mastectomy and Breast Reconstruction

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

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

This benefit covers:

- Reconstruction of the breast on which mastectomy was performed
- Surgery and reconstruction of the other breast to produce a similar appearance
- 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 for all members.

The ***Maternity Care*** benefit includes coverage for abortion.

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.

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, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother. In any case, plans and issuers also may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

Plan benefits are also provided for medically necessary supplies related to home births.

Professional Care

- 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.

Please Note: Attending provider as used in this benefit means a provider such as a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). 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. Please see the ***Surgery*** benefit for details on surgery coverage.

Please see the ***Preventive Care*** benefit for women's preventive care during and after pregnancy.

Medical Foods

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

This benefit covers:

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

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

This benefit does not cover:

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

Medical Transportation

This plan provides benefits for travel and lodging only for certain covered services as described below. Prior authorization is also required.

- Travel related to the covered transplants named in the ***Transplants*** benefit. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members when the member is not in the hospital and for their companion. 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 cellular immunotherapy and gene therapy. Benefits are provided for travel for the member and one companion to a designated provider outside the service area, when a designated provider is not available within the service area. Please see ***Cellular Immunotherapy and Gene Therapy***.

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

Benefits are provided for:

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

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

Companion Travel

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

Reimbursement of Travel Claims

You must pay for all travel expenses yourself and submit a Travel Claim Form. A separate claim form is needed for each patient and each commercial carrier or transportation service used. You can get Travel Claim Forms on our website at **premera.com**. You can also call us for a copy of the form.

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

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

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

This benefit does not cover:

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

Mental Health Care

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 real-time visits with your doctor or other provider via telephone, online chat or text, or other electronic methods (telemedicine).
- 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 (M.D. or D.O.) who is a psychiatrist, developmental pediatrician or pediatric neurologist
  - A licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
  - A licensed occupational or speech therapist
  - A licensed psychologist (Ph.D.)
  - A licensed community mental health agency or behavioral health agency that is also state-certified to provide ABA therapy.
  - A Board-Certified Behavior Analyst (BCBA). This means a provider who is state-licensed if the State licenses behavior analysts (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
- Washington state-licensed community mental health agency
- Licensed physician (M.D. or D.O.)
- Licensed psychologist (Ph.D.)
- 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" (please 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 his or her license.

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

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

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

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

The *Mental Health Care* benefit doesn't cover:

- Psychological treatment of sexual dysfunctions, including impotence and hypoactive sexual desire disorder
- 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 Therapy (Habilitation)

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 and occupational 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 visit maximum described in the ***Summary Of Your Costs***. 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.

For massage therapy coverage, please see the ***Massage Therapy*** benefit.

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, please see the dependent eligibility and enrollment guidelines outlined in the ***Medical Plan Eligibility And Enrollment*** section.

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, please see the ***Medical Plan Eligibility And Enrollment*** section.

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.

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, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother. In any case, plans and issuers also may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

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

Please Note: Attending provider as used in this benefit means a provider such as a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

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 services include repair of a dependent child's congenital anomaly. 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.

Essentials Drug List This plan uses a specific list of covered drugs, sometimes referred to as a "formulary." This list, called the Essentials drug list, includes preferred generic drugs, preferred brand-name drugs and non-preferred drugs. However, the Essentials drug list does not cover some of the drugs in certain drug classes. An example is proton pump inhibitors. Except for drugs and items listed under ***Exclusions*** below in this benefit, the Essentials drug list covers at least 1 drug in every drug class. (A drug class is a group of drugs that may work in the same way, have a similar chemical structure, or may be used to treat the same conditions or group of conditions.)

Drugs not included in the Essentials drug list are not covered by this plan.

Please call Customer Service or visit our website for more information or to find out if a certain drug is covered. If your drug is not covered, please work with your provider to find an alternative drug in that drug class that the plan does cover.

See Question 1 in ***Questions And Answers About Your Pharmacy Benefits*** below in this benefit to find out how to ask for coverage of a drug that is not in the Essentials drug list.

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

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.

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.

Birth Control

All FDA-approved female and male prescription and over-the-counter oral birth control drugs, supplies and devices. See ***Prescription Drug*** in the ***Summary Of Your Costs***. You must buy over-the-counter supplies and devices at the pharmacy counter. You do not need a prescription. For sterilization, shots or devices from your doctor, see ***Preventive Care***.

Preventive Drugs Required By The Affordable Care Act that your doctor prescribes.

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

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 or In-Network Specialty Pharmacies	30 days	Pay the cost-share in the ***Summary Of Your Costs*** at the pharmacy
Out-Of-Network Retail Pharmacies	30 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)	90 days	• Allow 2 weeks for your prescription to be filled. • Ask your doctor to prescribe up to a 90-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. The exceptions are for specialty drugs.
- 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. (The exception is a shot you give yourself.) Please see the ***Infusion Therapy*** benefit.
- Drugs to treat sexual dysfunction
- Drugs to manage your weight
- Medical equipment and supplies that are not listed as covered above. See the ***Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies*** benefit for coverage.
- Immunization agents and vaccines. See the ***Preventive Care*** benefit.
- Drugs for fertility treatment or assisted reproduction procedures.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered under your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact us (the health carrier) at the Customer Service phone number shown on the back cover of this booklet or visit our website at **www. premera.com/sebb**. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or **www.insurance.wa.gov**. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington State Department of Health at 360-236-4700 **www.doh.wa.gov**, or HSQACS@doh.wa.gov.

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?**

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

   Essentials Drug List

   This benefit makes use of our Essentials drug list, sometimes called 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 review medical studies, scientific papers and reports and other information on drugs and their uses to choose safe and effective drugs for the list.

   The Essentials drug list includes preferred generic drugs, preferred brand name drugs, preferred specialty drugs, and certain non-preferred generic, brand name and specialty drugs. (Preferred brand name drugs are brand name drugs that are only made by one drug company.) The Essentials drug list covers at least 1 drug in every drug class but does not cover all the drugs in some drug classes. Use the RX Search tool on our website or call Customer Service for a full list of drugs on the Essentials drug list.

   This plan also doesn't cover certain categories of drugs. These are listed under ***Exclusions*** earlier in this benefit.

   Certain drugs need prior authorization. Please see ***Prior Authorization*** above in this benefit 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 applicable brand name cost shares. See the ***Summary Of Your Costs*** for the amount you pay. However, if the prescriber allows you to take a generic drug instead of the brand-name drug, 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 costs 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.

Exceptions You or your provider may ask that the plan cover a drug or a dose that is not on the Essentials drug list. The drug may be covered if 1 of 3 things is true:

- You cannot tolerate the drugs that are on the Essentials drug list
- All covered drugs in any tier of the Essentials drug list will be (or have been) either ineffective or not as effective as the drug that is not on the list
- The dosage you need is not available in the drugs on the Essentials drug list.

If your request to cover a drug not on the Essentials drug list is approved, the plan will cover the drug. If your request is not approved, the plan will not cover the drug.

Exception Process The request can be made in writing, electronically or by phone. Your provider must give us a written or oral statement that confirms the need for the requested drug to treat your condition and states that the criteria above are met. We have the right to ask for medical records that relate to the request.

Within 5 calendar days after we get the information we need from your provider, we will let you or your provider know in writing if your request is approved

If Your Request Is Urgent We will respond to your request within 48 hours after we get the information we need from your provider if 1 of the following is true:

- Your health problem may put your life or health in serious danger.
- You have already started taking the drug.

The provider must confirm that 1 of the 2 situations above is true. The provider must also explain the harm that would come to you if we did not respond to the request within 48 hours.

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 can decide to make a drug preferred or non-preferred at any point in the year. The committee may also add or remove a drug from the Essentials drug list during the year. These changes can happen 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. We will also tell you if a drug you are taking is going to be removed from the Essentials drug list. The amount you pay for a drug is based on whether the generic, brand name or specialty drug is preferred or non-preferred 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't be changed. The plan's rules about substitution of generic drugs are described above in question 1.

You can appeal any decision you disagree with. Please 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 initiate 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*** 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 you have 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 the member has purchased more than a 180-day supply of birth control drugs at one time.

Exceptions to the supply limit are allowed as required by law:

- 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. For example, a drug with a $10 copay for a 30-day supply would have a per-day copay of 33 cents. If the member needed a 20-day supply of the drug, we would then multiply the 33 cents by 20.
- You can ask for up to a 12-month supply of birth control drugs. If you have a copay for the drug, you must 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.

Drug Discount Programs

Premera Blue Cross may receive rebates from its pharmacy benefit manager or other vendors. Such rebates are Premera Blue Cross's property. These rebates are retained by Premera Blue Cross and may be taken into account in setting subscription charges or may be credited to administrative charges and are not reflected in your allowed amount. The allowed amount is not adjusted to reflect rebates received as part of Drug Discount Programs.

In addition, the allowed amount that your payment for drugs is based on may be higher than the price Premera Blue Cross pays its pharmacy benefit manager or other vendors for those drugs. The difference constitutes Premera Blue Cross property. Premera Blue Cross is entitled to retain and shall retain the difference and may apply it to the cost of Premera Blue Cross's operations. If your drug benefit includes a copay, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowed amount. The allowed amount is not adjusted to reflect discounts received as part of Drug Discount Programs.

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, nasal spray flu vaccine (FluMist), 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, such as:

- Mammograms (includes 3D mammograms)
- X-rays and EKG tests
- Pap smears
- Prostate-specific antigen tests
- BRCA genetic tests for women at risk for certain breast cancers.

Pregnant Women'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

Colon Cancer Screening

For members who are 50 or older or who are under age 50 and at high risk for colon cancer. Includes:

- Barium enema
- Colonoscopy, sigmoidoscopy, fecal immunochemical test (FIT) 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.

Diabetes Preventive Program

- Weight Management Programs consisting of 31 lessons over a 12 month timeframe provided to non-Medicare members who are age eighteen (18) and older and have a BMI>25.

  Eligibility for the weight management programs is based on medication claims for:

  - Metformin only (no additional diabetes medications); or
  - Blood pressure medication and a cholesterol medication; or
  - Any weight loss medication

Members are not eligible if they are pregnant or are diagnosed with diabetes mellitus.

Please see the Chronic Condition Management for additional diabetes benefit information.

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. Information regarding available nicotine habit-breaking programs can be obtained by contacting your provider.

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

Birth Control

- Birth control devices, shots and implants. The plan will cover up to a 12-month supply of birth control pills you receive in your provider's office. A 12-month supply of birth control is also available through your pharmacy.

  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***.
- Vasectomy done in a doctor's office with a local anesthetic

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 (USPSTF) 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 doctor 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 doctor 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 doctor 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. Please see ***Prescription Drug***.
- Routine newborn exams while the child is in the hospital after birth. Please 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. Please see the ***Hospital Inpatient*** 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. Please 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.

For additional information regarding preventive care services or programs above, please call Customer Service at the number shown on the back cover of this booklet.

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. Benefits are also provided for the following professional services when provided by a qualified in-network 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
- Real-time visits via online and telephonic methods with your doctor or other provider (telemedicine).

For surgical procedures performed in a provider's office, surgical suite or other facility benefit information, please see the ***Surgery*** benefit.

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

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

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

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

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

Electronic Visits

This benefit will cover electronic visits (e-visits) 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
- Rehabilitation that is not part of a cardiac or pulmonary rehabilitation program. Please see ***Rehabilitation Therapy***.

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 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.

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 medically necessary outpatient therapy:

- Physical, speech, hearing and occupational therapies. Physical, speech, and occupational assessments and evaluations related to rehabilitation are also covered.
- Cardiac and pulmonary rehabilitation programs.
- 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 Services

This benefit includes:

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

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

This benefit does not cover:

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

Spinal and Other Manipulations

This benefit covers 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 ***Massage Therapy***, ***Rehabilitation Therapy*** and ***Neurodevelopmental Therapy*** benefits.

Please see the ***Summary of Your Costs*** for benefit limitations.

Substance Use Disorder

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

Covered services include services provided by a state-approved treatment program or other licensed or certified provider.

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 treatment is medically necessary.

Please Note: Medically necessary detoxification is covered in any medically necessary setting. Detoxification in the hospital is covered under the ***Emergency Room*** and ***Hospital*** benefits.

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

- Treatment of alcohol or drug use or abuse that does not meet the definition of "Chemical Dependency" as stated in the ***Definitions*** section of this booklet
- 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.

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

For services to change gender, please see the ***Transgender Services*** 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 to be pre-approved before you get them. See ***Prior Authorization*** for details.

Therapeutic Injections

This benefit covers:

- Shots given in the doctor'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***)

Transgender Services

This benefit covers medically necessary services to change the gender you were born with. To find the amounts you are responsible for, please see the ***Summary Of Your Costs***.

This benefit covers services which meet the standards in our medical policy. Call Customer Service or visit our website **at www. premera.com/sebb** for the policy.

See the ***Surgery*** benefit for gynecological, urologic and genital surgery for covered conditions other than gender identity disorder or gender dysphoria.

See the ***Prescription Drug*** benefit for coverage of prescription drugs associated with transgender procedures.

See the ***Mental Health Care*** benefit for coverage of mental health services.

This benefit does not cover:

- Transgender surgery for members under 18
- Cosmetic procedures that are not medically necessary to make the gender change. Examples are hair removal and procedures to change the voice.
- Surgery to change the appearance of prior gender change procedures except when medically necessary to correct medical complications.

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." Please 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. (Please see the ***Definitions*** section in this booklet for the definition of "experimental/investigational services.") We reserve the right to base coverage on all of the following:

- Organ transplants and bone marrow/stem cell reinfusion procedures must meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

  The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our 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)

    Please 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 (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (please see the ***Surgery*** benefit).
- Your medical condition must meet our 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, except as 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" (please 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 services, such as:

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

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

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

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

Virtual Care – On Demand

On demand virtual care provides ease, convenience and immediate access to medical care for limited low-level acute medical conditions such as a urinary tract infection or strep throat using several technology solutions. This benefit covers on-demand virtual care using secure chat, text, voice or audio messaging, and video chat.

This benefit does not cover real-time visits between you and your doctor via online and telephonic methods (telemedicine). See the ***Professional Visits And Services*** and ***Mental Health Care*** benefits.

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, please see the Mental Health Care, Preventive Care, Rehabilitation Therapy, Professional Visits And Services, and Diagnostic Services benefits.

Surgical Weight Loss Treatment

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

This benefit will be provided only when covered services are furnished by in-network providers.

Weight loss surgery requires pre-approval. See ***Prior Authorization*** later 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.

1. The member must be diagnosed as one of the following:
   - Morbidly obese with a Body Mass Index (BMI) greater than 40; or
   - Overweight with a BMI greater than 35 with at least one of the following conditions, including but not limited to:
     - Established coronary heart disease
     - Other atherosclerotic disease
     - Type 2 diabetes that is not controlled by drug therapy
     - High blood pressure that is not controlled by medical management
     - Sleep apnea documented as moderate or severe
2. During the 2 years immediately before the surgery, the member has actively taken part in a weight-loss program that is supervised by a physician and that lasted at least 6 months in a row. The program must be documented in the member's medical records.
3. A licensed mental health provider has evaluated the member to establish emotional stability and ability to cope with surgical limitations

For specific surgical treatment benefit information, please see the ***Hospital Inpatient Care***, ***Hospital Outpatient Care*** and ***Surgery*** benefits.

The *Weight Management* benefit does not cover:

- Non-surgical weight management
- Procedures or treatments that are experimental and investigational (please 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?

Benefits of this plan are limited to "medical emergencies" (please see the ***Definitions*** section in this booklet) when you receive services and supplies outside the service area (please see ***Definitions***). Covered services and supplies for medical emergencies can be furnished by any providers that meet the following requirements:

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

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

OUT-OF-AREA CARE

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

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

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

Note: Only in a few cases will this plan cover care from providers that are not in the networks chosen by the Group. Please see ***How Providers Affect Your Costs*** for details.

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 outside our service area that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. Please see ***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 1-800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.

More Questions

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

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.

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.

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.

  If you do not ask for prior authorization, and the plan covers the service, you will have to pay a penalty. The amount is 50% of the allowed amount. However, you will not have to pay more than $1,500 per occurrence in penalties. In addition, you also have to pay your cost-share.

Prescription Drugs

The plan has a specific list of prescription drugs that must have prior authorization before you get them at a pharmacy. The E4 drug list is on our website at **premera.com/sebb**. Your provider can ask for a prior authorization by faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website.

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

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

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

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

- A set number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis
- Certain drugs from certain pharmacies, or you may need to get a prescription drug from an appropriate medical specialist or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

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 do have separate requirements:

- Emergency care and 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.

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.

Please Note: It is your responsibility to get prior authorization for any services that require it when you see a provider that is out-of-network. If you do not get a prior authorization, the services will not be covered 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 must pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Amounts over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.

Exceptions to Prior Authorization For Out-Of-Network Providers

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

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

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

CLINICAL REVIEW

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 Web site. You or your provider may review them at **www.premera.com/sebb**. 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.

CHRONIC CONDITION MANAGEMENT

Premera has contracted with a consumer digital health company (the program manager) to give members access to a program of monitoring and health management support for certain chronic conditions described below. The program is voluntary. Your digital readings/test results and other data are not shared with Premera, the Washington State Healthcare Authority, or the School Employees Benefits Board Program, or anyone other than the program manager. However, the program manager can share your data with your doctor or with someone close to you if you choose. Please note that this program is voluntary. If you choose to participate in this program, these services will be provided to you at no cost. Each member that qualifies to participate will be contacted directly and provided a detailed program schedule.

Diabetes

For members who have Type 1 or Type 2 diabetes. If you qualify and join the chronic condition management program, you will get:

- A blood glucose meter from the program manager that uploads blood sugar readings to a personal online account.
- A lancing device and lancets.
- Test strips for this meter. You can reorder test strips using the meter or online. The strips will be sent to you directly.
- Real-time reminders to check blood sugar or to take medication, and tips based on your blood sugar readings that can help keep your levels within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app.

Pre-Diabetes

For members who meet pre-diabetes criteria followed by the Centers for Disease Control. If you qualify and join the program, you will get:

- A digital scale from the program manager that uploads readings to a personal online account.
- Lessons that cover topics such as nutrition, activity and stress.
- Coaching and support via phone, text, e-mail or the program manager's mobile app.

EXCLUSIONS

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

Amounts Over The Allowed Amount

This plan does not cover amounts over the allowed amount as defined by this plan. If you get services from a non-contracted provider, you will have to pay any amounts for your services that are over the allowed amount.

Assisted Reproduction

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

- Drugs to treat infertility or that are required as part of assisted reproduction procedures.
- Artificial insemination or Assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure.

- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

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

Benefits From Other Sources

This plan does not cover services that are covered by other insurance, such as:

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage, or Medical Premises coverage
- Any type of liability insurance, such as homeowners' coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits That Have Been Exhausted

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

Broken Or Missed Appointments

Charges For Records Or Reports

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

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, this plan does not cover personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport. This does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Dietary assistance, including “Meals on Wheels”

Complications

This plan does not cover complications of a non-covered service, including follow-up services or effects of those services, except services defined as emergency care. See ***Definitions***.

Cosmetic Services

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

Counseling, Education And Training

This plan does not cover counseling and, education or training in the absence of illness. This includes but is 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

Court-Ordered Services

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

Custodial Care

This plan does not cover custodial care, however see ***Hospice Care***.

Dental Care

This plan does not cover dental care that is not addressed under ***Dental Care, Chemotherapy And Radiation Therapy***. This exclusion also doesn't apply to dental services covered under the ***Temporomandibular Joint Disorders (TMJ) Care*** benefit.

Donor Breast Milk

Environmental Therapy

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

Experimental Or Investigative Services

This plan does not cover any service or supply that is experimental or investigative, see ***Definitions***.

Family Members Or Volunteers

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

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

Governmental Facilities

This plan does not cover services provided by a state or federal hospital which is not an in-network facility that are not emergency care or required by law or regulation.

Hair Analysis

Hair Loss

This plan does not cover:

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

Hospital Admission Limitations

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

- The service cannot be provided without the use of a hospital
- You have a medical condition that makes hospital care medically necessary

Illegal Acts and Terrorism

This plan does not cover illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt.

Laser Therapy

Benefits are not provided for low-level laser therapy.

Military Service And War

This plan does not cover illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units.

Non-Covered Services

This plan does not cover services or supplies:

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

Non-Treatment Charges

- Charges for provider travel time
- Transporting a member in place of a parent or other family member, or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.

Non-Treatment Facilities, Institutions Or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, and juvenile detention facilities. Benefits are provided for medically necessary treatment received in these locations. See ***Covered Services*** for specific benefit information.

Not Medically Necessary

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

Orthodontia

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

Provider's Licensing Or Certification

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

Recreational, Camp And Activity Programs

This plan does not cover recreational, camp and activity-based programs. These programs are not medically necessary and include:

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

Serious Adverse Events and Never Events

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

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

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

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

Services And Supplies Furnished By Out-Of-Network Providers

Services and supplies furnished by out-of-network providers. However, this exclusion doesn't apply to certain covered services, supplies and providers. (Please see ***Benefits For Out-Of-Network Providers*** under ***How Providers Affect Your Costs*** and ***Prior Authorization For Out-Of-Network Providers***.)

Services or Supplies For Which You Do Not Legally Have To Pay

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

Sexual Dysfunction

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

Vision Exams

This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.

Vision Hardware

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

Vision Therapy

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

Voluntary Support Groups

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

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.

WHAT IF I HAVE OTHER COVERAGE?

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

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

When you have more than one health plan, "coordination of benefits (COB)" makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims

with your primary plan first. If you have Medicare, Medicare may submit your claims to your secondary plan. Please see ***COB's Effect On Benefits*** below in this section for details on primary and secondary plans.

If you do not know which is your primary plan, you or your provider should contact any of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan(s) to determine which is primary and will let you know within 30 calendar days.

Caution: All health plans have timely filing requirements. If you or your provider fails to submit your claim to your secondary plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary plan, you or your provider will need to submit your claim to the secondary plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers any changes in your coverage.

COB Definitions

For the purposes of COB:

- A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB doesn't apply is treated as a separate plan.
  - "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.
  - "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.
- **This plan** means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your Premera Blue Cross plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.
- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See ***COB's Effect On Benefits*** later in this section for rules on secondary plan benefits.
- **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that isn't covered by any of your plans isn't an allowable expense.

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

  The exceptions to this rule are when a Medicare, a Medicare Advantage plan, or a Medicare Prescription Drug plan (Part D) is primary to your other coverage. In those cases, the allowable expense set by the Medicare plan will also be the allowable expense amount used by the secondary plan.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

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 Washington regulations is primary to a complying plan unless the rules of both plans make the complying plan primary. The exception is group coverage that

supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

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

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

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

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child’s 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.

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

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

COB's Effect On Benefits

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

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. **The secondary plan is never required to pay more than its benefit in the absence of COB plus any savings accrued from prior claims incurred in the same calendar year.**

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

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.

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

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

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

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

SUBROGATION AND REIMBURSEMENT

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

Definitions The following terms have specific meanings in this contract:

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

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

legal expenses. Our share is that percentage of the legal expenses reasonable and necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

MEDICAL PLAN ELIGIBILITY AND ENROLLMENT

In these sections, “health plan” is used to refer to a plan offering medical, vision, or dental coverage, or a combination developed by the School Employees Benefits Board (SEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility

The school employee’s SEBB Organization will inform the school employee whether or not they are eligible for benefits upon employment and whenever their eligibility status changes. The communication will include information about the school employee’s right to appeal eligibility and enrollment decisions. Information about a school employee’s right to an appeal can be found on page 60 of this certificate of coverage. For information on how to enroll, see the ***Enrollment*** section.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the ***Enrollment*** section. The SEBB Program or SEBB Organization verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent’s eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner as defined in the state statute and substantially equivalent legal unions from other jurisdictions as defined in the Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in subsection (g) of this section. Children are defined as the subscriber’s:
    a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    b. Children of the subscriber’s spouse, based on the spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to a subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
    c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    d. Children of the subscriber’s state-registered domestic partner, based on the state-registered domestic partner’s establishment of a parent-child relationship, except when parental rights have been terminated. The child’s relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber’s legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and
g. Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before age 26. The following requirements apply to dependents with a disability:
   - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;
   - The subscriber must notify the SEBB Program in writing when the child is no longer eligible under this subsection;
   - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support;
   - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support; and
   - The SEBB Program with input from the medical plan will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

Enrollment

A subscriber or dependent is eligible to enroll in only one SEBB medical plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same, or two different SEBB Organizations may be enrolled as a both parents but is limited to a single enrollment in SEBB medical.

A school employee may waive enrollment in SEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. If a school employee waives enrollment in SEBB medical, the school employee cannot enroll eligible dependents.

How to enroll

A school employee must use the SEBB My Account online enrollment system or submit a School Employee Enrollment form to their SEBB Organization when they become newly eligible for SEBB benefits. The online enrollment or form must be received no later than 31 days after the date the school employee becomes eligible. If the school employee does not enroll online or return the School Employee Enrollment form by the deadline, the school employee will be enrolled in Uniform Medical Plan Achieve 1, a tobacco use premium surcharge will be incurred, and any eligible dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment.

To enroll an eligible dependent, the school employee must include the dependent's enrollment information in SEBB My Account or on the form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility. The dependent will not be enrolled in SEBB health plan coverage if the SEBB Program or the SEBB Organization is unable to verify their eligibility within the SEBB Program enrollment timelines.

All other subscribers may enroll by submitting the required forms to the SEBB Program. The SEBB Program must receive the school employee's elections no later than 60 days from the date the school employee's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB Program, whichever is later. The school employee's first premium payment and applicable premium surcharges are due no later than 45 days after the election ends as described above. Premiums and applicable premium surcharges associated with continuing SEBB medical, must be made to the HCA as well as premiums associated with continuing SEBB medical, dental, and vision insurance coverage. For more information see ***Options For Continuing SEBB Medical Coverage*** on page 58.

A subscriber or their dependents may also enroll during the SEBB Program's annual open enrollment (see ***Annual Open Enrollment*** on page 53) or during a special open enrollment (see ***Special Open Enrollment*** beginning on page 54). The subscriber must provide proof of the event that created the special open enrollment.

A school employee must notify their SEBB Organization to remove dependents within 60 days of the last day of the month when the dependent no longer meets the eligibility criteria described under ***When May A Subscriber Enroll Or Remove Eligible Dependents?*** on page 56. All other subscribers must notify the SEBB Program to remove a dependent within 60 days of the last day of the month when the dependent no longer meets the eligibility criteria described under ***When May A Subscriber Enroll Or Remove Eligible Dependents?*** on page 56. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent losing eligibility to continue SEBB medical coverage under one of the continuation coverage options described on page 58 of this certificate of coverage;
- The subscriber being billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for a dependent that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

When Medical Coverage Begins

For a school employee and their eligible dependents **enrolling when the school employee is newly eligible**, SEBB medical coverage begins the first day of the month following the date the school employee becomes eligible.

Exceptions:

1. The school employee's benefits will begin on the first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB Organization.
2. When a school employee establishes eligibility toward SEBB benefits at any time in the month of August, the SEBB benefits begin on September 1 only if the school employee is also determined to be eligible for the school year that begins on September 1.

For a subscriber or their eligible dependents **enrolling during a special open enrollment**, SEBB medical coverage begins the first day of the month following the later of the event date or the date the online enrollment or required form is received.

Exceptions:
If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, SEBB medical coverage begins as follows:

- For an employee, medical coverage will begin the first day of the month in which the event occurs;
- For the newly born child, medical coverage begins the date of birth;
- For a newly adopted child, medical coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
- For a spouse or state-registered domestic partner of a subscriber, medical coverage will begin the first day of the month in which the event occurs.
    a. Enrollment of an extended dependent or a dependent with a disability will begin the first day of the month following the later of the event date or eligibility certification.

Annual Open Enrollment

School employees may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll in or change their medical plan
- Waive their medical plan enrollment
- Enroll after waiving medical plan enrollment
- Enroll or remove eligible dependents

Other Subscribers may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll in or terminate enrollment in a medical plan
- Enroll or remove eligible dependents
- Change their medical plan

The school employee must submit the change online in SEBB My Account or return the required enrollment/change form to their SEBB Organization. All other subscribers must submit the form to the SEBB Program. The form must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1st of the following year.

Special Open Enrollment

A subscriber may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both. A special open enrollment event must be an event other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits. The special open enrollment may allow a subscriber to:

- Enroll in or change their medical plan
- Waive their medical plan enrollment
- Enroll after waiving medical plan enrollment
- Enroll or remove eligible dependents

To make an enrollment change, the school employee must make the change online in SEBB My Account or submit the required forms to their SEBB Organization. All other subscribers must submit the form to the SEBB Program. The forms must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the SEBB Program or SEBB Organization will require the subscriber to provide proof of the dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception: If a school employee wants to enroll a newborn or child whom the school employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in SEBB health plan coverage, the school employee should notify their SEBB Organization by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. School employees should contact their payroll or benefits office for the required forms.

See ***When May A Subscriber Enroll Or Remove Eligible Dependents***" on page 56.

When can a subscriber change their health plan?

Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becomes eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber has a change in employment from a SEBB Organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:
    a. The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or
    b. The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.

c. As used in this subsection the term “public school district” shall be interpreted to not include charter schools.

5. Subscriber’s dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
6. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan otherwise there will be limited accessibility to network providers and covered services;
7. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent enrolls in coverage under Medicaid or a state Children’s Health Insurance Program (CHIP), or the subscriber or the subscriber’s dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP;
10. Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in Medicare, the subscriber must select a new medical plan;
11. Subscriber or their dependent’s current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA);
12. Subscriber or their dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment. The subscriber may not change their health plan election if the subscriber or a subscriber’s dependent physician stops participation with the subscriber’s health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment of a high risk pregnancy.

Note: If an enrollee’s provider or health care facility discontinues participation with this plan, the enrollee may not change medical plans until the SEBB Program’s next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the SEBB Program determines that a continuity of care issue exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can a school employee waive their medical plan coverage, or enroll after waiving coverage?

Any one of the following events may create a special open enrollment:

1. School employee gains a new dependent due to:
    a. Marriage or registering for a state-registered domestic partnership;
    b. Birth, adoption, or when the school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. School employee or a school employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;
3. School employee has a change in employment status that affects the school employee's eligibility for their employer contribution toward their employer-based group medical;
4. The school employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group medical;
    Note: Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation.
5. School employee or a school employee's dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment;

6. School employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence results in the dependent losing their health insurance;
7. A court order requires the school employee or any other individual to provide a health plan for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);
8. School employee or a school employee's dependent enrolls in coverage under Medicaid or a state children's health insurance program (CHIP), or the school employee or a school employee's dependent loses eligibility for coverage under Medicaid or CHIP;
   Note: A school employee may only return from having waived SEBB medical for the events described in (8) of this subsection. A school employee may not waive their SEBB medical for the events described in (8) of this subsection
9. School employee or a school employee's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP;
10. School employee or a school employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;
11. School employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

When Can A Subscriber Enroll Or Remove Eligible Dependents?

To enroll a dependent, the subscriber must include the dependent's enrollment information and provide any required documents as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility is not verified. Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
   a. Marriage or registering a state-registered domestic partnership;
   b. Birth, adoption or when a school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
   Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation.
5. Subscriber or their dependent has a change in enrollment under an employer-based group medical insurance plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment;
6. Subscriber dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence results in the dependent losing their health insurance;
7. A court order requires the school employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the school employee or a school employee's dependent loses eligibility for coverage under Medicaid or CHIP; or
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or a CHIP.

National Medical Support Notice (NMSN)

When a NMSN requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

1. The subscriber may enroll their dependent child and request changes to their health plan coverage as described under subsection (3) of this section. School employees use SEBB My Account or submit the required forms to their SEBB Organization. All other subscribers submit the required forms to the SEBB Program.

2. If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the SEBB Organization or the SEBB Program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:
    a. The child's other parent; or
    b. Child support enforcement program.
3. Changes to health plan coverage or enrollment are allowed as directed by the NMSN:
    a. The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN;
    b. A subscriber who has waived SEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;
    c. The subscriber's selected health plan will be changed if directed by the NMSN;
    d. If the dependent is already enrolled under another SEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN; or
    e. If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.
4. Changes to health plan coverage or enrollment as described in subsection (3)(a) through (e) of this section will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

When Medical Coverage Ends

Medical plan enrollment ends on the following dates:

1. The SEBB Organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
2. The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or
3. The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty (630) hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

Premium payments and applicable premium surcharges become due the first of the month in which medical coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if an enrollee dies or asks to terminate their medical plan before the end of the month.
If an enrollee or newborn eligible for benefits under obstetrics and newborn care is confined in a hospital or skilled nursing facility for which benefits are provided when SEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation coverage or conversion to other health plan coverage if they apply within the timelines explained in the ***Options For Continuing SEBB Medical Coverage*** on page 58 or ***Conversion of coverage*** on page 59.

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remains unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or applicable premium surcharge. If the subscriber is not eligible for the employer contribution and has premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, the subscriber's medical

coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharge was paid.

A school employee who needs the required forms for an enrollment or benefit change may contact their SEBB Organization. All other subscribers may contact the SEBB Program at the number on the back cover of this booklet.

Medicare Eligibility and Enrollment

If a school employee or their dependent becomes eligible for Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

For a school employee and their enrolled spouse or state-registered domestic partner age 65 and older, the SEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, a school employee age 65 and older may choose to waive their SEBB medical plan and choose Medicare as their primary insurer. If a school employee does so, the school employee cannot enroll in SEBB medical. The school employee can again enroll in SEBB medical during a special open enrollment or annual open enrollment.

In most situations, a school employee and their spouse or state-registered domestic partner can elect to defer Medicare Part B enrollment without a penalty when the school employee terminates employment and enroll during a Special Enrollment Period. If Medicare eligibility is due to disability, the school employee or a school employee's dependent must contact Medicare about deferral of enrollment.

Upon retirement, Medicare will become the primary insurance, and the Public Employees Benefits Board (PEBB) medical plan becomes secondary. See ***Options for Coverage Under PEBB Retiree Insurance*** on page 58.

Options For Continuing SEBB Medical Coverage

A school employee and their dependent covered by this medical plan has options for continuing insurance coverage during temporary or permanent loss of eligibility. There are two continuation coverage options for SEBB medical plan enrollees:

1. SEBB Continuation Coverage (COBRA)
2. SEBB Continuation Coverage (Unpaid Leave)

These two options temporarily extend group insurance coverage when the enrollee's SEBB medical plan coverage ends due to a qualifying event. SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. SEBB Continuation Coverage (Unpaid Leave) is an alternative created by the SEBB Program with wider eligibility criteria and qualifying event types. Enrollees who qualify for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

You must notify the SEBB Program in writing within 30 days if, after electing COBRA, you or your dependent become enrolled in Medicare (Part A, Part B, or both) or become covered under other group health plan coverage. If a subscriber enrolls in COBRA and then becomes eligible for Medicare, their enrollment in COBRA coverage will be terminated when the subscriber is eligible for Medicare. This may cause the COBRA coverage to be terminated early, before the subscriber has used all the months they would otherwise be entitled to. Subscribers who are already enrolled in Medicare when they enroll in COBRA will not have their coverage terminated early.

The SEBB Program administers both continuation coverage options. Refer to the *SEBB Continuation Coverage Election Notice* for details.

Subscribers also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The subscriber's dependents also have options for continuing insurance coverage for themselves after losing eligibility.

Option For Coverage Under Public Employees Benefits Board (PEBB) Retiree Insurance

A retiring school employee is eligible to continue enrollment or defer enrollment in Public Employees Benefits Board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Transitional continuation coverage

School employees and their dependents may gain temporary eligibility for School Employees Benefits Board (SEBB) benefits, on a self-pay basis, if they meet the following criteria:

1. A school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2019, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to enroll in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of eighteen months.
2. A dependent of a SEBB eligible school employee who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2019, who loses eligibility because they are not an eligible dependent may enroll in medical, dental, and vision for a maximum of thirty-six months.
3. A dependent of a school employee who is continuing medical, dental, or vision coverage through a SEBB Organization on December 31, 2019, may elect to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act (COBRA) for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program**.**

Family And Medical Leave Act Of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the FMLA. The SEBB Organization determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility.
If a school employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by the Health Care Authority (HCA), with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled ***Options For Continuing SEBB Medical Coverage*** on page 58.

Paid Family Medical Leave Act

A school employee on approved leave under the Washington state Paid Family and Medical Leave Program may continue to receive the employer contribution toward SEBB benefits in accordance with the Paid Family and Medical Leave Program. The Employment Security Department determines if the school employee is eligible for the Paid Family and Medical Leave Program. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under the Paid Family and Medical Leave Program, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by HCA, with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled ***Options For Continuing SEBB Medical Coverage*** on page 58.

General provisions

Payment of premium during a labor dispute

Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB Organization may pay premiums directly to the Health Care Authority (HCA) if the school employee’s compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the school employee's compensation is suspended or terminated, HCA shall notify the school employee immediately by mail to the last address of record, that the school employee may pay premiums as they become due.
If coverage is no longer available to the school employee under this certificate of coverage, then the school employee may purchase an individual medical plan from this plan at a premium rate consistent with premium rates filed with the Washington state Office of the Insurance Commissioner.

Conversion of coverage

Enrollees (including spouses and dependents of a subscriber terminated for cause) have the right to switch from SEBB group medical to an individual conversion plan offered by this plan when they are no longer eligible to continue the SEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion program differ from those of the enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call Customer Service at the number listed on the back of this booklet.

Appeal rights

Any current or former school employee of a SEBB Organization or their dependent may appeal a decision made by the SEBB Organization regarding SEBB eligibility, enrollment, or premium surcharges to the SEBB Organization.

Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or premium surcharges to the SEBB Appeals Unit.
Any enrollee may appeal a decision regarding the administration of SEBB medical by following the appeal provisions of the plan, with the exception of eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations
Any provision of this certificate of coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

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 for medical benefits to us, follow the simple steps below.

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 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 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.

COMPLAINTS AND APPEALS

We know healthcare doesn't always work perfectly. Our goal is to listen, take care of you, and make it simple. If it doesn't go the way you expect, you have two options:

- Complaint – is when you are not satisfied with customer service or with the quality of or access to medical care. You can call Customer Service if you have a complaint. We may ask you to send the details in writing. We will send a written response within 30 days.
- Appeal – is a request to review of a specific decision we have made.
    - A decision to pay for less than the full cost of your claim
    - A limit or restriction on otherwise covered benefits
    - A decision to deny or partly deny your request for coverage of a benefit

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. It also includes denials of drugs not on the plan's list of covered drugs. (See Prescription Drug for details
Enrollment canceled or not issued	No Coverage	You are not eligible to enroll or stay in the plan

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

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

APPEAL LEVELS

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2	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.	180 days from the date you were notified of our Level 2 appeal decision. OR 180 days from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL

Here are your options for submitting an appeal:

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

Submit supporting documentation. This may include chart notes, medical records, or a letter from your doctor.

Within 72 hours, we will confirm in writing that we have received your request.

If you need help filling out an appeal, or would like a copy of the appeals process, please call Customer Service. If you would like to review the information used for your appeal, please call Customer Service. The information will be sent as soon as possible and free of charge.

Choose Someone To Appeal For You

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

Appeal Response Time Limits

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

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

WHAT HAPPENS IF YOU HAVE ONGOING CARE

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

If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, 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. Please see the table above. Urgent appeals are only available for services you are currently receiving or have not yet received.

Examples of urgent situations are:

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

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

HOW TO ASK FOR AN EXTERNAL REVIEW

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

We will forward your medical records and other information to the Independent Review Organization (IRO). If you have additional information on your appeal, you may send it to the IRO.

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and Premera immediately. Premera will accept the IRO decision.

If the IRO:

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

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

Washington Consumer Assistance Program
5000 Capitol Blvd.
Tumwater, WA 98501

1-800-562-6900

E-mail: “mailto:cap@oic.wa.gov”.

ADDITIONAL INFORMATION ABOUT YOUR COVERAGE

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

You may also ask for the following information:

- How to access care under this plan, including from providers who do not contract with us. See ***How Providers Affect Your Costs*** earlier in this booklet.
- Our confidentiality policies
- Your right to seek and pay for care outside of this plan
- The plan's drug list, also called a "formulary"
- How we pay providers
- How providers’ payment methods help promote good patient care
- A statement of all benefit payments in each year that have been counted toward this plan’s benefit limitations, visit, day, or dollar benefit maximums or other overall limitations
- How to file a complaint and a copy of our process for resolving complaints
- How to appeal decisions you don't agree with.
- How to access specialists
- How to get prior authorization when needed
- How we monitor quality and performance, including accreditation status of our plans with national managed care organizations
- Use of the health employer data information set (HEDIS) to track performance

If you want to receive this information, please go to our Web site. If you don’t have access to the Web, please call Customer Service. Our Web address and phone numbers are shown on the back cover of this booklet.

Also, when you enrolled in this plan, you got information such as how to access our provider directory and preferred drug lists. If you need this information again, please call Customer Service.

You may also ask Customer Service for more information about:

- Other healthcare plans we offer
- A description of the payment arrangements we use to pay providers

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how your Group’s contract with us and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

Conformity With The Law

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

Entire Contract

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

- The contract face page and Standard Provisions
- The benefit booklet(s)
- The Group's signed application
- The Funding Arrangement Agreement between the Group and us
- All attachments, endorsements and riders included or issued hereafter

No agent or representative of Premera Blue Cross or any other entity is authorized to make any changes, additions or deletions to the Group Contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done over the signature of an officer of Premera Blue Cross.

Evidence Of Medical Necessity

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

The Group And You

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

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 the contract between Premera 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, we'll be entitled to recover these amounts. Please 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, at our option:

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

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

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

Member Cooperation

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

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 Group Contract

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

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

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

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

Notice Of Other Coverage

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

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

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 or your Group is 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

We have the right to recover amounts we paid that exceed the amount for which we're liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment 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.

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

Right To And Payment Of Benefits

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

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

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

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

Venue

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

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

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

Women's Health and Cancer Rights Act of 1998

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

Workers' Compensation Insurance

This contract doesn't replace, affect or supplement any state or federal requirement for the Group to provide workers' compensation insurance, employer's liability insurance or other similar insurance. When an employer is required by law to provide or has the option to provide workers' compensation insurance, employer's liability insurance or other similar insurance and doesn't provide such coverage for its employees, the benefits available under this plan won't be provided for illnesses and/or injuries arising out of the course of employment that are or would be covered by such insurance, unless otherwise excepted under the ***Exclusions*** section in this booklet.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan. As part of the routine operation of this plan, we use our expertise and judgment to apply the terms of the contracts for making decisions in specific benefits, eligibility and claims situations. For example, we use the medical judgment and expertise of Medical Directors to determine whether claims for benefits meet the definitions below of "Medically Necessary" or "Experimental/Investigational Services. We also have medical experts who determine whether care is custodial care or skilled care and reasonably interpret the level of care covered for your medical condition. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal, have independent review or bring a civil challenge to any eligibility or claims determinations.

Adverse Benefit Determination

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

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

Affordable Care Act

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

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Chemical Dependency (also called "Substance Use Disorder")

An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use

- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

Clinical Trials

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:

- An institutional review board that complies with federal standards for protecting human research subjects and
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
  - The United States Department of Defense
  - The United States Department of Veterans' Affairs
  - A nongovernmental research entity abiding by current National 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.

Congenital Anomaly Of A Dependent Child

A marked difference from the normal structure of an infant's body part, that's present from birth and manifests during infancy.

Cost-Share

The member's share of the allowed amount for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See the ***Summary Of Your Costs*** to find out what your cost-share is.

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

Detoxification is active medical management of medical conditions due to substance intoxication or substance withdrawal, which requires repeated physical examination appropriate to the substance, and use of medication. Observation alone is not active medical management.

Effective Date

The date when your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

Eligibility Waiting Period

The length of time that must pass before an employee or dependent is eligible to be covered under the Group's health care plan. If an employee 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 Care

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
- 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 care, hospitalization, maternity and newborn care, mental health and chemical dependency 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/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Group

The large employer that is a party to the Group Contract. A large employer is one that had an average of at least 51 common law employees on its normal work days in the preceding calendar year. It must also have at least 51 common law employees on the first day of the current contract term.

The Group is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees.

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A "hospital" will never be an institution that's run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly

- For the treatment of chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition or pregnancy.

Injury

Physical harm caused by a sudden event at a specific time and place. It's 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.

Medical Emergency (also called "Emergency")

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It's of no use in the absence of illness or injury.

Medical Facility (also called "Facility")

A hospital, skilled nursing facility, state-approved chemical dependency treatment program or hospice.

Medically Necessary

Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to 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 generally 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.

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.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Abortion is included as part of obstetrical care.

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 an 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*** benefits under this plan.

Physician

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

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

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

Plan (also called "This Plan")

The benefits, terms and limitations set forth in the contract between us and the Group, of which this booklet is a part.

Prescription Drug

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 to determine if a service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness. You must ask for prior authorization before the service is delivered.

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

Provider

A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the state of Washington and other such facilities are included as required by state and federal law.

In states other than Washington, "provider" means health care practitioners and facilities licensed or certified consistent with the laws and regulations of the state in which they operate, and provide health care services consistent with applicable state requirements.

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

- Acupuncturists (L.Ac.) (in Washington, also called East Asian Medicine Practitioners (E.A.M.P.)
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dentists (D.D.S. or D.M.D.)

- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following health care facilities and other providers of health care services and supplies will be considered health care providers for the purposes of this plan, as long as they're licensed or certified by the State (unless otherwise stated) and the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

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.

Service Area

The area in which we directly operate provider networks, which includes all of Washington State (except for Clark County) and Alaska.

Skilled Care

Care that's ordered by a physician and requires the medical knowledge and technical 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.

Subscriber

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

Subscription Charges

The monthly rates set by us as consideration for the benefits offered in this plan.

We, Us and Our

Means Premera Blue Cross in the state of Washington, and Premera Blue Cross Blue Shield of Alaska in the state of Alaska.

Where To Send Claims

MAIL YOUR CLAIMS TO

Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To:
Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

Contact the Pharmacy Benefit Administrator At:
1-800-391-9701
www.express-scripts.com

Customer Service

Mailing Address
P.O. Box 91059
Seattle, WA 98111-9159

Physical Address
7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Phone Numbers
Local and toll-free number:
1-800-807-7310

Local and toll-free TRS number:
711

Care Management

Prior Authorization And Emergency Notification
Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

Local and toll-free number:
1-800-807-7310
Fax: 1-800-843-1114

Complaints And Appeals

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

BlueCard

1-800-810-BLUE(2583)

Website

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

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