Premera Blue Cross HMO

Plan 4000

Core Plus

100000105

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

Premera Blue Cross HMO 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 HMO. This booklet replaces any other benefit booklet you may have received. The Group has delegated authority to Premera Blue Cross HMO 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 specific eligibility, 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:	WA Farm Bureau Healthcare Trust
Effective Date:	October 1, 2023
Group Number:	100000105
Plan:	Core Plus
Certificate Form Number:	WFB4000HMO23

INTRODUCTION

Welcome

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

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

What your health plan can help you do

Know your plan

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

Find care

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

Get care

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

Be well

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

Contact Information

Where To Send Claims

MAIL YOUR CLAIMS TO

Premera Blue Cross HMO
P.O. Box 327
Seattle, WA 98111-0327

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Administrator At

1-800-391-9701
www.express-scripts.com

Customer Service

Mailing Address

Premera Blue Cross HMO
P.O. Box 327
Seattle, WA 98111-0327

Physical Address

6707 220th St. S.W.
Mountlake Terrace, WA 98043

Phone Numbers

Local and toll-free number:
1-800-722-4661

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

Care Management

Prior Authorization

Premera Blue Cross HMO
P.O. Box 327
Seattle, WA 98111-0327

Local and toll-free number:
1-800-722-4661
Fax 1-800-843-1114

Complaints and Appeals

Premera Blue Cross HMO
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

BlueCard

1-800-810-BLUE(2583)

Website

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

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Premera Blue Cross HMO Overview

This plan is a Health Maintenance Organization. This means that the plan is designed to cover care from in-network providers. Your plan provides you benefits for covered services from providers you access within the Sherwood HMO network in Washington. Referrals are required from your Primary Care Provider (PCP) to see specialists for most services, except for emergency services. A prior authorization may be required in addition to a referral. Please see ***How Providers Affect Your Costs*** for more information.

If a referral is not provided and you choose to receive services from providers or facilities except as specifically indicated in the ***Covered Services*** section, those services will not be covered under this plan. You will be responsible for 100% of the cost for these services and any amounts you pay will not apply to your out-of-pocket maximum, except services required by federal or state law. Please see ***When Do I Need A Referral To See A Specialist?*** for more information.

A list of HMO network providers including PCPs and specialists is available by contacting customer service or accessing the Premera HMO website at premera.com.

Copay

	In-Network Providers	**Out-of-Network Providers**
Primary Care Provider copay	$10 Copay	Not covered
Specialist copay	$65 Copay	Not covered
Emergency room copay (ER copay waived if admitted)	$300	$300

Coinsurance

	In-Network Providers	**Out-of-Network Providers**
	20%	Not covered

Deductible

	In-Network Providers	**Out-of-Network Providers**
Individual deductible	$4,000	Not covered
Family deductible (embedded)	$8,000	Not covered

Out-of-Pocket-Maximum

	In-Network Providers	Out-of-Network Providers
Individual out-of-pocket maximum	$8,000	Not covered
Family out-of-pocket maximum	$16,000	Not covered

Quick Care Guide

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

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

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

Out-of-Network	Services from healthcare providers and hospitals that have not contracted with Premera Blue Cross HMO. This could mean the service will not be paid for at all by Premera HMO. You may also be required to submit the claim yourself.
Out-of-Pocket Maximum	The out-of-pocket maximum is the most you pay for covered services in a year before Premera HMO pays 100% of the allowed amount. The out-of-pocket maximum includes an Individual and a Family Out-of-Pocket Maximum. Expenses that do not apply to the out-of-pocket maximum include, but not limited to: • Charges above the allowed amount. • Services above any benefit maximum limit or durational limit. • Services not covered by this plan. • Services from out-of-network providers, except as prohibited by state or federal law. • Covered services that do not apply to the out-of-pocket maximum. See ***Covered Services***.
Prior Authorization	Some services must be authorized in writing before you get them, in order to be eligible for coverage. The conditions, time limits and maximum limits are described in this booklet.
Referral	A written request from your Primary Care Provider (PCP) to receive certain services from a specialist.
Visit, day, or hour limits	Some covered services have a maximum number of visits, days, or hours. After you reach this limit, you pay 100% out-of-pocket, whether or not you've met your deductible.
Year	The consecutive 12-month period that starts on your health plan's effective date. For this plan, it's a calendar year which begins on January 1 and ends on December 31.

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

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

Office visit charges
$120

Allowed amount
$100

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

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

Your total responsibility
$20

Important Plan Information

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

Getting Care

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

- The provider's office can often look up your insurance and see that you're eligible.
- Download the Premera mobile app to get a digital ID card.
  iPhone and Android users can get the app from the Apple or Google Play App Store
- Call Premera HMO customer service at 800-722-4661 for your ID number.

Discover your care choices

You can see or call	When you need	What to do
In-network Primary care and Specialty care providers	Routine and specialty care	Select in-network providers. A referral is required for certain specialists. See ***When Do I Need A Referral To See A Specialist?***
Virtual care	A visit with a provider, counselor, or psychiatrist without going to an office. Have your appointment by computer, tablet, or mobile device wherever you are.	Set up your account at premera.com, then connect any day, any time, including weekends and holidays. Call **1-800-234-5678.**
Urgent Care/Walk-in clinic	Same-day care for medical issues that need urgent attention but are not life threatening. Examples include, rashes, flu, minor burns or cuts, x-rays, and lab tests.	Sign in to premera.com and click "Find Care." Choose "Health Service Clinic/Center" or "urgent care" to search for locations closest to you.
Emergency services	Life-threatening emergency services	**Call 911** or go to an emergency room
24-Hour NurseLine	Advice from a registered nurse for illnesses like fevers, the flu, and minor injuries.	Call **1-866-224-8541** (open 24 hours a day, seven days a week).

Allowed Amount

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply. The allowed amount is described below.

In-Network

The allowed amount is the fee that we have negotiated with providers who have signed contracts with us and are in your provider network.

Out-of-Network

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

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

Generally, non-emergent care services provided by out-of-network providers is not covered. However, you or your in-network provider may ask for a prior authorization to cover the out-of-network provider at the in-network benefit level if the services are medically necessary and only available from an out-of-network provider. You or your in-network provider must ask for prior authorization before you receive the services. See ***Prior Authorization*** for details.

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

Emergency Services

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

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

Note: Out-of-network ground ambulances are always paid based on billed charges.

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

How Providers Affect Your Costs

MEDICAL SERVICES

This plan is a Health Maintenance Organization (HMO). This means that the plan provides you benefits for covered services from providers in the Sherwood HMO network. You have access to one of the many providers included in this network.

- Hospitals, physicians and other providers in this provider network are called "in-network providers."
- This plan makes available to you a sufficient number and types of providers to give you access to all covered services in compliance with applicable Washington state regulations governing access to providers.
- A list of in-network providers is available in our Sherwood HMO provider directory. These providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you.
- If you choose to receive services from out-of-network providers or facilities except as specifically indicated in the ***Covered Services*** section, those services will not be covered under this plan. You will be responsible for 100% of the cost for these services and any amounts you pay will not apply to your out-of-pocket maximum, except services required by federal or state law.

Primary Care Providers

This plan auto-assigns you a primary care provider (PCP) at the time you enroll in the plan. Your PCP must be in the network and be a specific provider type.

- This provider will be your PCP unless you decide to change to another. You can change your PCP at any time by calling Premera HMO customer service or signing into your member portal.

- A list of in-network providers can be found in our Sherwood HMO provider directory on premera.com.
- For more details and a list of the specific provider types, see the ***Important Plan Information*** section.

HOW TO SELECT A PCP PROVIDER

The provider directory shows which providers you can select as your PCP. The Sherwood HMO provider network directory is available any time on our website at premera.com. You may also request a copy of this directory by calling customer service at the number located in ***Contact Information*** or on your Premera HMO ID card. We update this directory regularly, but it is subject to change. We suggest that you call us for current information and to verify that your provider, their office location, or provider group is included in the Sherwood HMO network before you receive services.

- You can change your PCP at any time by calling Premera HMO customer service or signing into your member portal.
- If you are having difficulty choosing an available PCP, contact us and we will help you select a PCP or visit premera.com. You'll find resources to help you choose a PCP who's a good fit for you..
- You may select one PCP for an entire family or a different PCP can be selected for each member on the plan.

IMPORTANT NOTE: Services received from out-of-network providers are not covered under this plan, except services required by federal or state law. See ***In-Network Benefits for Out-of-Network Providers***.

Primary Care Office Visits

Primary Care Office Visits	You pay the PCP cost share for primary care office visits.
Primary Care Providers (PCP)	• Family practice physician • General practice provider • Geriatric practice provider • Gynecologist • Internist • Naturopath • Nurse practitioner • Obstetrician • Pediatrician • Physician Assistant You do not need prior authorization from Premera HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of in-network health care professionals who specialize in obstetrics or gynecology, contact Customer Service at 1-800-722-4661.
Related Information	• All other covered services provided by your selected PCP during the primary care office visit are subject to standard cost shares. • Example: If you select a PCP and see that PCP for a cut that needs stitches, you will pay the PCP cost share for the office visit and will pay your plan's deductible and/or coinsurance for the stitching procedure.

Specialty Care Provider Services

Specialty care provider services include consultations, evaluations and treatment by physician specialists. Services provided by certain in-network specialists require a referral from your PCP. You can determine if you need a referral to a specialist by accessing Premera HMO's member portal and your PCP can also access this information through the provider portal.

WHEN DO I NEED A REFERRAL TO SEE A SPECIALIST?

Specialist Office Visits	You pay the specialist cost share for office visits with a specialist.
All services provided by a specialist require a referral, except for the following (Specialists must be in-network)	The following is a list of services provided by a specialist that **do not** require a referral from a PCP. Any service provided by a specialist that is not listed below requires a referral. Please contact customer service, your PCP, or use your member portal for more information about referrals. • Acupuncture • Ancillary services (x-ray, lab, pathology) • Anesthesia • Behavioral health • Blood bank services • Chiropractic care • Emergency services • Family planning services • Ground and air ambulance (emergent/urgent care) • Home medical equipment (HME) (some supplies require prior authorization) • Inpatient Hospital Ancillary Professional Fees • Naturopathic services (non-PCP) • Newborn care (up to 31 days) • Obstetric care • Outpatient physical, occupational, speech, and massage therapy (benefit limits apply) • Pediatric dental • Preventive services • Spinal manipulations • Sterilization • Urgent care
Second Opinions	• Second opinions from an in-network provider for medical diagnosis or treatment • A referral from your PCP is required • A referral for a second opinion does not apply to any other services provided by this provider.
Related Information	• All other covered services provided by your PCP during the primary care office visit are subject to standard cost shares. • Example: If you select a PCP and see that PCP for a cut that needs stitches, you will pay the PCP cost share for the office visit and will pay your plan's deductible and/or coinsurance for the stitching procedure.

HOW DO I GET A REFERRAL?

Your PCP must provide a referral before you can receive care from specialists. Some services provided by in-network specialists do not require referrals as listed in ***When Do I Need A Referral To See A Specialist?*** For more information about referrals, access your member portal. Your PCP can also access this information through the provider portal.

If a referral is not provided and you choose to receive services from providers or facilities except as specifically indicated in the ***Covered Services*** section, those services will not be covered under this plan. You will be responsible for 100% of the cost for these services and any amounts you pay will not apply to your out-of-pocket maximum, except services required by federal or state law.

In-Network Providers	• Networks of hospitals, physicians and other providers that are part of our Sherwood HMO network in Washington. • These providers provide medical services at a negotiated fee. This fee is the allowed amount for in-network providers. • When you receive covered services from an in-network provider your medical bills will be reimbursed at the in-network provider benefit level. • In-network providers will not charge more than the allowed amount.
Out-of-Network Providers	• Services provided by providers not in the Sherwood HMO network are not covered unless indicated below.

In-Network Benefits for Out-of-Network Providers	The following covered services and supplies provided by out-of-network providers will always be covered at the in-network level of benefits:
	• Emergency services for a medical emergency and urgent care services. (Please see the ***Definitions*** section for definitions of these terms.) This plan provides worldwide coverage for emergency services.
	  ◦ Prior authorization and without regard as to whether the health care provider furnishing the services is a network provider.
	  ◦ Emergency services furnished by an out-of-network provider will be reimbursed in compliance with applicable laws.
	• Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
	• Facility and hospital-based provider services received from a hospital that has a provider contract with Premera Blue Cross HMO.
	• See also ***Balance Billing Protections***.
	If a covered service is not available from an in-network provider, you can apply to receive benefits for services provided by an out-of-network provider. However, you or your in-network provider must request this **before** you get the care. See ***Prior Authorization*** for details.

Contracted Health Care Benefit Managers

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

Balance Billing Protections

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

Emergency Services from an out-of-network hospital or facility or from an out-of-network provider that works at the hospital or facility.

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

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

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

For the above services, you will pay no more than the plan's in-network cost-shares. Premera Blue Cross HMO will work with the out-of-network provider to resolve any issues about the amount paid. Premera HMO will also send the plan's payments to the provider directly.

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

Care Management

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

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment and to help us identify if you might benefit from case management.

PRIOR AUTHORIZATION

You must get Premera HMO's approval for some services before the service is performed, or you may not have coverage for the service. This process is called prior authorization. A referral to an in-network provider or facility may be required in addition to obtaining prior authorization for services.

There are two different types of prior authorization required:

Prior Authorization Type	What it means
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 HMO can confirm that these services are medically necessary and covered by the plan.
Cover Out-of-Network Providers at In-Network Cost Shares	You or your in-network provider must get prior authorization in order for an out-of-network provider to be covered at the plan's in-network benefit level, except for urgent and emergency services. Please see ***Exceptions To Prior Authorization For Out-of-Network Providers*** below for more information.

How Prior Authorization Works

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

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

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

1. Prior Authorization for Benefit Coverage

Benefit	Description
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 HMO customer service before you receive a service to find out if your service requires prior authorization. • **In-network providers or facilities** are required to request prior authorization for the service. • **Out-of-network providers and facilities and facilities** will not request prior authorization for the service. You have to ask Premera HMO to prior authorize the service. You also have to get prior authorization for coverage of services from an out-of-network provider. See ***Prior Authorization for Out-of-Network Provider Coverage*** below. **If you do not ask for prior authorization, and the plan covers the service, you will have to pay a penalty.** The penalty amount is 50% of the allowed amount. However, you will not have to pay more than $1,500 penalty per occurrence. 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 list is on our website at **premera.com**. Your provider can ask for a prior authorization by faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website. • If your provider does not get prior authorization, when you go to the pharmacy to get your prescription, the pharmacy will tell you that you need it. • You or your pharmacy should inform your provider of the need for prior authorization. • Your provider can fax us an accurately completed prior authorization form for review.
	Emergency Fill

	The plan may cover a small supply of the drug to allow more time for the prior authorization. The cost-shares shown in ***Covered Services*** will apply. In-Network pharmacies will find out if an emergency fill is covered for your drug. The authorized amount of the emergency fill will be no more than the prescribed amount, up to a seven-day supply or the minimum packaging size available at the time the emergency fill is dispensed. Please see the process for emergency fills on our website at **premera.com**. If an emergency fill is not allowed for your drug, you can still buy the drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See ***How Do I File A Claim?*** for details.
	Limitations Sometimes, benefits for some prescription drugs may be limited to one or more of the following: • A set number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment. • Certain drugs for a specific diagnosis • Certain drugs from certain pharmacies, or you may need to get a prescription drug from an appropriate medical specialist or a specific provider • Step therapy, meaning you must try a generic drug or a specified brand name drug first • Drug synchronization, meaning the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. Cost-shares are adjusted if the fill is less than the standard refill amount in compliance with state law. These limits are based on medical standards, the drug maker's advice, and your specific case. They are also based on FDA guidelines and medical articles and papers.
Exceptions to Prior Authorization	The following services do not require prior authorization for benefit coverage: • The first six visits provided by an in-network provider for rehabilitation and habilitation therapy, spinal manipulative treatment or acupuncture. • Emergency services, urgent care, and emergency hospital admissions, including emergency drug or alcohol detox in a hospital. • Services provided under involuntary commitment statutes are covered. • Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth. Emergency admissions and childbirth hospital admissions do not require prior authorization, but you must notify us as soon as reasonably possible.

2. Prior Authorization for Out-of-Network Provider Coverage

Out-of-Network Provider Services	Generally, non-emergent care services provided by out-of-network providers are not covered. However, you or your in-network provider may ask for a prior authorization to cover the out-of-network provider at the in-network benefit level if the services are medically necessary and only available from an out-of-network provider. You or your in-network provider must ask for prior authorization before you receive the services. You will need to reach out to your in-network provider to have them submit the appropriate forms. You may also initiate the process yourself by calling the toll-free customer support number on the back of your ID card. When we receive your request, we will confirm there are no in-network providers who can provide the requested services. If there is an in-network provider available, your prior authorization request for coverage of services from an out-of-network provider will not be authorized. **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 ask for prior authorization, and the plan covers the service, you will have to pay a penalty.** The penalty amount is 50% of the allowed amount. However, you will not have to pay more than $1,500 penalty per occurrence. You also have to pay your cost-share**.** The prior authorization request for an out-of-network provider must include the following: • A statement explaining how the provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from an in-network provider, and • Medical records needed to support the request. If the out-of-network services are authorized, the plan will cover the service. **However, in addition to the cost shares, an out-of-network provider can bill you for any amounts over the allowed amount if the provider does not have a contract with us,** except for emergency services, covered air ambulance services, or as prohibited by law**. Amounts over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.**
Exceptions to Prior Authorization for Out-of-Network Providers	Out-of-network providers can be covered without prior authorization for emergency services, urgent care, and hospital admissions for a medical emergency. This includes hospital admissions for emergency drug or alcohol detox or for childbirth. If you are admitted to an out-of-network hospital due to an emergency condition, those services are always covered. We will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital. Emergency services furnished by an out-of-network provider will be reimbursed on the same basis as a network provider and you will not be billed for charges above the allowed amount under the Balance Billing Protection Act (BBPA) and No Surprises Act (NSA).

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

CLINICAL REVIEW

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

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

You can find our medical policies at **premera.com**.

PERSONAL HEALTH SUPPORT PROGRAMS

Premera Blue Cross HMO personal health support programs are designed to help make sure your health care and treatment improve your health. You will receive individualized and integrated support based on your specific needs. These services could include working with you and your doctor to ensure appropriate and cost-effective medical care, to consider effective alternatives to hospitalization, or to support both of you in managing chronic conditions.

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

CONTINUITY OF CARE

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

COC applies in these situations:

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

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

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

We will notify you immediately if the provider contract termination will happen within 30 days. When a termination for cause provides us less than 30 days' notice, we will make a good faith effort to assure that

a written notice is provided to you immediately.

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

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

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

Continuity of care does not apply if your provider:

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

When continuity of care ends, you may continue to receive services from this same provider, however non-emergent covered care from the provider will be paid at the out-of-network level. If we deny your request for continuity of care, you may request an appeal of the denial. Please see ***Complaints and Appeals***.

Covered Services

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

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

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

Related Benefit Information

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

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

Medical policies 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).

Acupuncture

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

Important things to know:

- After the visit limits are met, you pay 100% of costs out of pocket.
- Acupuncture limit is not applicable for treatment of substance use disorders.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-Network
Office and clinic visits	12 visits / year	$10 copay, deductible waived	Not covered
Other outpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?

Acupuncture that is used to:

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

Allergy Testing and Treatment

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Testing and treatment	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Ambulance

Medical transportation, usually for emergencies.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Ambulance	No limit	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance

Benefit Overview

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

Additional Information

Ambulances that do not have an agreement with us or the local Blue Cross and/or Blue Shield Licensee will be paid based on billed charges.

App-Based Care

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

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

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Virtual General Medical Visit	No limit	$10 copay, deductible waived	Not covered
Virtual Mental Health Visit	No limit	$10 copay, deductible waived	Not covered
Virtual Substance Use Disorder Visit	No limit	$10 copay, deductible waived	Not covered

Benefit Overview

What services are included?

- Chat
- Text
- Voice
- Audio messaging and video chat

At-Home Care

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

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

Home health care

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

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

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

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

Cost Overview

Important things to know:

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

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Home visits	130 visits / year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

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

Skilled hourly nursing

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

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

Examples of skilled hourly nursing services include:
- Ventilator dependent or tracheostomy patients.
- Patients who are chronically ill and require extensive care to remain at home.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Skilled hourly nursing	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Blood Products and Services

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Blood products and services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?

- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.

Cellular Immunotherapy and Gene Therapy

Treatment which uses your body's own immune system or genes to treat disease.

Important things to know:

- **These treatments must meet three criteria in order to be covered:**
  - be prescribed by a provider
  - meet Premera HMO's medical policy (see premera.com or call customer service), and
  - be approved by Premera HMO before they happen (see ***Prior Authorization***)
- What you pay and what is covered is based on the type of service you get. See ***Related Benefit Information*** below for details.

Cost Overview

 What is covered?	 What is the limit?	 What will I pay?	
		In-network	**Out-of-network**
Cellular Immunotherapy and Gene Therapy Services	No limit	Covered as any other service	Not covered

Benefit Overview

What services are included?	• Medically necessary cellular immunotherapy and gene therapy, like CAR-T
Related benefit information	• You may have additional costs for other services such as x-rays and lab. See those covered services for details. • If you travel more than 50 miles for these therapies, keep all receipts. You can be reimbursed for some expenses, up to $7,500 per episode of care. See ***Medical Transportation*****.** • See ***Prior Authorization*** for more information on getting prior approval for services. • Facility charges are covered under ***Hospital***. • Professional services are covered under ***Professional Visits and Services***.

Chemotherapy and Radiation Therapy

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Facility charges	No limit	Deductible, then 20% coinsurance	Not covered
Professional services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Outpatient chemotherapy and radiation therapy. • Supplies, solutions, and drugs used during a chemotherapy or radiation visit. • Tooth extractions to prepare your jaw for radiation therapy.
Related benefit information	• See ***Prior Authorization*** for more information on getting prior approval for services. • See ***Prescription Drug*** for information on oral chemotherapy. • See ***Cellular Immunotherapy and Gene Therapy*** for information on these treatments, which is covered for some types of cancer.

Chiropractic Adjustments

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Adjustments	12 visits / year	$10 copay, deductible waived	Not covered

Benefit Overview

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

Clinical Trials

Qualified clinical trials are scientific studies that test and try to improve treatments. Often, clinical trials are for cancer and other life-threatening conditions.

Important things to know:

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

Cost Overview

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

Benefit Overview

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

Additional Information

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

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

- The US Department of Health and Human Services, National Institutes of Health, or its institutes or centers.
- The United States Food and Drug Administration (FDA).
- The US Departments of Veterans Affairs or Defense.

- An institutional review board in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the National Institutes of Health.
- A qualified research entity that meets the criteria for National Institutes of Health Center Support Grant eligibility.
- A National Institutes of Health (NIH) cooperative group or center that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative group and the NCI Community Clinical Oncology Program.

Dental Injury and Facility Anesthesia

This section will go over two types of dental care:

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

Dental Injuries

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

Important things to know:

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

Cost Overview

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

Benefit Overview

What services are included?	**Dental Injury** • Exams • Consultations • Treatment of dental injuries to teeth, gum, and jaw • Oral surgery
What is excluded? (Premera HMO pays 0%)	• Routine dental care, such as x-rays and cleanings, are not covered under this benefit. • Injuries from biting or chewing, including injures from a foreign object in food. • Oral surgery treating any fracture of the mandible (jaw) (This is covered under ***Surgery***).
Related benefit information	• You may have additional costs for other services such as x-rays and lab. See those covered services for details.

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

Anesthesia for Routine Dental Care

Anesthesia for routine dental care is covered for any one of the following reasons when medically necessary and is only covered when covered by an anesthesia professional at an outpatient surgery center, inpatient facility or when under inpatient professional care:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Anesthesiologist	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient surgery center	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Diagnostic, X-ray, Lab, and Imaging

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

Important things to know:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Preventive care screening/tests	No limit	No charge	Not covered
Basic	No limit	Deductible, then 20% coinsurance	Not covered
Major	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Bone density screening for osteoporosis.
	• Cardiac tests, including ECG, EKGs, and nuclear cardiology.
	• Colonoscopy.
	• Diagnostic images and scans, such as:
	  ◦ X-ray.
	  ◦ Ultrasound.
	  ◦ Mammogram (including 3-D) for a medical condition.
	  ◦ MRI (Magnetic Resonance Imaging).
	  ◦ MRA (Magnetic Resonance Angiography).
	  ◦ CT scan (Computed Tomography).
	  ◦ PET scan (Positron Emission Tomography).
	• Laboratory services.
	• Lung function tests.
	• Neurological and neuromuscular tests.
	• Pathology tests.
	• Diagnosis and treatment of underlying medical conditions that may cause infertility.

What is excluded? (Premera HMO pays 0%)	• Treatment of infertility, including but not limited to surgery, fertility drugs, and other medications associated with fertility treatment. • Non-diagnostic testing required for employment, schooling, screening, or public health reasons that are not for the purpose of treatment.

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

Dialysis

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

Important things to know:

- The cost of dialysis can be substantial. We recommend calling customer service to find in-network providers.
- If you have end-stage renal disease (ESRD), you may be eligible for Medicare. We recommend that you enroll in Medicare as soon as possible if you are eligible. This will reduce your costs substantially.
- Medicare has a waiting period, generally the first 90 days after dialysis starts. Medicare doesn't start covering any of your costs until after that waiting period.
- As soon as you are enrolled in Medicare Part B, Premera Blue Cross HMO will pay your Medicare Part B premiums. Premera Blue Cross HMO will continue to pay these premiums for as long as you are enrolled in this plan and eligible for Medicare due to ESRD.

Cost Overview

 What is covered?	 What is the limit?	 What will I pay?	
		In-network	Out-of-network
During Medicare's waiting period (ESRD)	No limit	Deductible, then 20% coinsurance	Not covered
After Medicare's waiting period (ESRD)	No limit	No charge	Not covered

Benefit Overview

What services are included?	• Dialysis treatments in an outpatient setting or in your home.
Related benefit information	• See ***Prescription Drugs*** for medications for use after you leave the dialysis facility.

Emergency Services

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

Important things to know about emergency services:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Facility charges (ER copay waived if admitted)	No limit	$300 copay, then deductible, 20% coinsurance	$300 copay, then in-network deductible, 20% coinsurance
Professional services	No limit	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance

Benefit Overview

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

Foot Care

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

Examples of medical conditions include:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
In an office or clinic	No limit	See Professional Visits and Services	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Gender Affirming Care

Medically necessary services and care related to gender-affirming medical care or surgery.

Important things to know:

- Benefits are provided for all gender affirming surgical services which meet the criteria of the Premera HMO medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from customer service, or at **premera.com**.
- Gender-affirming surgery must be approved by Premera HMO ahead of time. See ***Prior Authorization*** for details.
- Gender affirming surgery results in multiple charges for things like the facility and professional services. You may receive separate bills for each charge.
- Hormone treatments are covered under the ***Prescription Drug*** benefit.

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Office and clinic visits	No limit	See Professional Visits and Services	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

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

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

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

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Home medical equipment, orthotics, prosthetics, and supplies	No limit	Deductible, then 20% coinsurance	Not covered
Foot orthotics and therapeutic shoes (diabetes-related: no limit)	$300 / calendar year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**External Prosthetics and Orthotic Devices:** To replace, correct, or straighten a body limb. **Home Medical Equipment and supplies (**fitting costs and sales tax) such as: • Wheelchairs. • Hospital beds. • Traction equipment. • Crutches. • Ventilators. • Insulin pump / blood glucose monitor and supplies. **Orthopedic Shoes and Shoe Inserts:** For the treatment of complications from diabetes or other medical disorders that cause foot problems. •
What is excluded? (Insurance pays 0%)	• Supplies or equipment not primarily intended for medical use. • Special or extra-cost convenience features. • Items such as exercise equipment and weights. • Physical changes to your house or personal vehicle (like elevators). • Over-bed tables, vision aids, and telephone alert systems.

	• Non-wearable defibrillators, trusses, and ultrasonic nebulizers • Over-the-counter orthotic braces and/or cranial banding. • Blood pressure cuffs/monitors (even if prescribed by a physician). • Bed-wetting (enuresis) alarm. • Compression stockings which do not require a prescription. • Orthopedic shoes used for sport, recreation, or similar activity. • Penile prostheses. • Hair prostheses, such as wigs or hair weaves, transplants and implants.
Related benefit information	• See ***Rehabilitation Therapy*** for additional benefit information. • See ***Prescription Drugs*** for some diabetic testing supplies which can be purchased in a pharmacy • See ***Surgery*** for prosthetics, intraocular lenses, equipment, or devices which require surgery • Breast pumps are covered under ***Preventive Care.*** • Not all equipment or supplies are covered. Some items need prior authorization from us (see ***Prior Authorization***).

Hospice Care

A facility or program that provides supportive care and symptom management. Hospice is specific to terminally ill members while palliative care can be provided to others with serious illness.

Important things to know:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay?	
		In-network	Out-of-network
Home visits	No limit within the 6-month lifetime maximum	Deductible, then 20% coinsurance	Not covered
Respite care	240 hours within the 6-month lifetime maximum	Deductible, then 20% coinsurance	Not covered
Inpatient facility care	10 days within the 6-month lifetime maximum	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Nursing care provided by or under the supervision of a registered nurse. • Medical social services provided by a medical social worker who is working under the direction of a physician; this may include counseling for the purpose of helping you and your caregivers to adjust to the approaching death. • Services provided by a qualified provider associated with the hospice program. • Short term inpatient care provided in a hospice inpatient unit or other designated hospice bed in a hospital or skilled nursing facility; this care may be for the purpose of occasional respite for your caregivers, or for pain control and symptom management. • Home medical equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness. • Home health aide services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care. • Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills. • Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms. • Palliative care for members facing serious, life-threatening conditions, including expanded access to home based care and care coordination. Participation in palliative care is usually approved for 12 months at a time and may be extended based on the member's specific condition.
Whose services are covered?	When provided by a hospice that is Medicare-certified or is licensed or certified by the state it operates in, the following are covered: • A registered nurse. • A licensed practical nurse. • A licensed physical or occupational therapist. • A certified respiratory therapist. • A certified speech. • A home health aide directly supervised by one of the above listed providers. • A licensed social worker.
What is excluded? (Premera HMO pays 0%)	• Over-the-counter drugs, solutions, and nutritional supplements. • Services provided to someone other than the ill or injured member. • Services of family members or volunteers. • Services, supplies or providers not in the written plan of care or not named as covered in this benefit. • Non-medical services, such as spiritual, bereavement, legal or financial counseling. • Normal living expenses, such as food, clothing, and household supplies; housekeeping services.

Hospital

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient facility charges	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient facility charges	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Inpatient room and board. • Provider services. • Intensive care or special care units. • Operating rooms, procedure, and recovery rooms. • Surgical supplies and anesthesia. • Drugs, blood, medical equipment, and oxygen for use in the hospital. • X-ray, lab, and testing billed by the hospital. • Medically necessary detoxification.
What is excluded? (Premera HMO pays 0%)	• Any days of inpatient care beyond what is medically necessary to treat the condition. • Hospital stays that are only for testing, physical exams, checkups, medical evaluations, or observations, unless: ○ The tests can't be done without the use of a hospital.

	○ You have a medical condition that makes hospital care medically necessary.
Related benefit information	• Services received from out-of-network providers are not covered under this plan, except services required by federal or state law. See ***How Providers Affect Your Costs*** for details. • Non-emergency inpatient hospitalizations require prior authorization. See ***Prior Authorization*** for details.

Infusion Therapy

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

Examples of infusion include:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Infusion therapy treatments	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Mastectomy and Breast Reconstruction

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Mastectomy and breast reconstruction	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Maternity Care

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Professional care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient hospital, birthing centers, and short-stay hospitals	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Routine prenatal visits. • Diagnostic and screening procedures, and genetic counseling. • Delivery of your baby, including home birth. • Additional post-delivery care, when the attending provider decides it's necessary, and it's based on accepted medical practice. • Medically necessary donor human milk obtained from a milk bank for inpatient use when ordered by licensed healthcare provider. • Abortion.
Whose services are covered?	• Physician (M.D. or D.O.), or a physician's assistant. • Certified nurse midwife (C.N.M). • A licensed midwife. • Advanced registered nurse practitioner (A.R.N.P).

What is excluded? (Premera HMO pays 0%)	• Assisted reproduction technologies such as:
	  • Artificial insemination or in-vitro fertilization.
	  • Services to make you more fertile or for multiple births.
	  • Reversing sterilization surgery.

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

Medical Foods

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Medical foods	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Medical Transportation

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
For Transplants	$7,500 limit per transplant	Deductible, then 0% coinsurance	In-network deductible, then 0% coinsurance
Cellular Immunotherapy and gene therapy	$7,500 per episode of care for travel lodging maximum	No charge	No charge

Benefit Overview

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

	• Reimbursement for travel before contacting Premera HMO 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 HMO to perform the services. • Travel related to participation in a clinical trial. • Travel insurance.
Related benefit information	• See ***Transplants*** for covered transplants. • See ***Ambulance*** for emergent and planned non-emergent transportation services.

Additional Information

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

Reimbursement of Travel Claims

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

To be reimbursed, attach the following documents to the Travel Claim form:

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

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

Mental Health Care

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	$10 copay, deductible waived	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient and residential facility care	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient professional care	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are covered?	• Inpatient care. • Outpatient care (including virtual care). • Residential facility care. • Individual or group therapy. • Family therapy, including couples therapy. • Laboratory and testing services. • Take home drugs you get in a facility. • Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders. • Services provided in your home, when medically appropriate. • Applied behavioral analysis (ABA) therapy (see ***Additional Information***).
Whose services are covered?	• A state licensed or approved facility, program, or agency that provides mental health services within the scope of their state licensure. • A state licensed or certified clinicians that provides mental health services within the scope of their state licensure or certification.

	• Any other provider listed under "provider" in the ***Definitions*** section who is licensed or certified in the state where care is provided, and who is providing care within the scope of their license. • Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care. • See ***Additional Information*** for who can provide ABA services.

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

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

Additional Information

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

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

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

- A licensed physician (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 or behavioral health agency that is state-certified to provide ABA therapy.
- A Board-Certified Behavior Analyst (BCBA), who is state licensed in states that license behavior analysts (like Washington), or certified by the Behavior Analyst Certification Board in states that do not license. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.
  A therapy assistant/behavioral technician/paraprofessional when their services are supervised and billed by a licensed provider or a BCBA.

Neurodevelopmental (Habilitation) Therapy

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

Important things to know:

- A visit is counted as one treatment for each type of therapy. Multiple visits with the same provider in one day count as one visit. If you see three different providers in one day, that will count as three visits.
- Once you have met the visit maximum for the year, no more benefits will be applied. (See ***Mental Health Care*** for therapies provided for mental health conditions such as autism.)
- Habilitation therapy is therapy that assists a person to keep, learn or improve skills and functioning for daily living.

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Outpatient care	25 visits / year	$65 copay, deductible waived	Not covered
Inpatient care	30 days / year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Physical, speech, and occupational therapy assessments related to treatment. • Outpatient care is covered when the member isn't confined in a hospital or other medical facility.
Whose services are covered?	• Inpatient facility services must be provided and billed by a hospital or rehabilitation facility that meets our clinical standards and will only be covered when services can't be done in a less intensive setting. • Outpatient services must be provided and billed by a hospital or rehabilitation facility that meets our clinical standards, physician, physical, occupational or speech therapist, chiropractor, or naturopath.
What is excluded? (Premera HMO pays 0%)	• Gym or swim therapy. • Custodial care. • Recreational, vocational, or education therapies. • Exercise or maintenance level programs. • Social or cultural therapy. • Treatment that isn't actively engaged in by the ill, injured, or impaired member.
Related benefit information	• See ***Rehabilitation Therapy, Psychological and Neuropsychological Testing*** for details on when to apply that benefit.

- See ***Mental Health Care*** for therapies provided for mental health conditions, such as autism.
- If you are using ***Rehabilitation Therapy*** for the same treatment reason, this benefit can't be applied at the same time. Once the maximum has been met for either, no additional benefits are available.
- You must get a prior authorization from us before you get inpatient treatment. See ***Prior Authorization*** for details.

Newborn Care

Care your baby gets during and immediately after birth.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Newborn care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Prescription Drugs

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

Important things to know:

- This plan uses a prescription drug formulary. **Please refer to your ID card for your prescription drug formulary.**
- Please see ***Premera Blue Cross HMO Overview*** for any prescription drug deductible information.
- If your copay is higher than the cost of a drug, you will always pay the lower amount.
- For specialty drugs to be covered, you must use a specialty pharmacy.
- You can find a list of included drugs (formulary) on premera.com. Certain drugs need prior approval, see ***Prior Authorization*** for more details.
- A covered drug you may be taking can change from preferred to non-preferred or become not covered. This can happen at any time throughout the year, if this does occur, we'll notify you in writing 60 days before the change happens.
- You must use the in-network mail-order pharmacy for refills of maintenance drugs. See ***Getting Your Prescriptions Filled*** below.

Cost Overview

 What is covered?	 What will I pay?	
	In-network	**Out-of-network**
Retail Pharmacy		
Generic drugs	$10 copay	Not covered
Preferred brand name drugs	$40 copay	Not covered
Non-preferred generic & brand name drugs	$150 copay	Not covered
Mail-Order Pharmacy		
Generic drugs	$25 copay	Not covered
Preferred brand name drugs	$100 copay	Not covered
Non-preferred generic & brand name drugs	$375 copay	Not covered

Specialty Pharmacy		
Preferred Specialty drugs (per prescription or refill)	$70 copay	Not covered
Non-Preferred specialty drugs (per prescription or refill)	$70 copay	Not covered
Other covered Drugs & Services		
Needles and syringes purchased with diabetic drugs	No charge	Not covered
Nicotine Habit-Breaking Drugs	No charge	Not covered
Drugs on the Affordable Care Act's preventive drug list	No charge	Not covered
Oral chemotherapy drugs	No charge	No charge
Birth control	No charge	Not covered

Benefit Overview

What services are included?	• FDA approved formulary prescription drugs. Federal law requires a prescription for these drugs. They are known as "legend drugs". • Glucagon and allergy emergency kits. • Inhalers, supplies and peak flow meters. • Some drugs that treat complex or rare health conditions are only covered at specialty pharmacies. • Prescribed preventive drugs required by the Affordable Care Act. • Compound medications that contain at least one covered prescription drug. • Certain prescription and generic over-the-counter drugs to break a nicotine habit. • Drugs associated with an emergency medical condition. **Diabetic Drugs and Supplies** • Prescribed drugs for shots that you give yourself, such as insulin. (Your cost-shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug and the deductible does not apply. Cost-shares for covered prescription insulin drugs apply towards the deductible.) • Needles, syringes, alcohol swabs, test strips, testing agents, and lancets. **Oral Chemotherapy** • Drugs you take by mouth that can be used to kill cancer cells or slow their growth. This benefit only covers the drugs that you get from a pharmacy. **Human growth hormone** • Human growth hormone is covered only for medical conditions that affect growth. It is not covered when the cause of short stature is unknown. Human growth hormone is a specialty drug. **Birth Control** • All FDA-approved prescription and over-the-counter oral birth control drugs, supplies, and devices, including emergency birth control are required to be covered by state and federal law. Over-the-counter supplies and devices must be bought at the pharmacy counter. • Can receive up to a 12-month supply for contraceptive drugs.
What is excluded? (Premera HMO pays 0%)	• Over-the-counter drugs and supplies that aren't listed above as covered, even if you have a prescription. • Non-formulary drugs. • Blood or blood derivatives. • Drugs used to improve your looks, such as drugs to increase hair growth. • Drugs for experimental or investigational use. • Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and injectable medications. • More refills than the number prescribed, or any refill dispensed more than one year after the prescriber's original order. • Drugs for use while you're in a health care facility or provider's office • Replacement of lost or stolen medication. • Drugs to treat sexual dysfunction. • Drugs to manage your weight. • Immunization agents and vaccines.

	• Drugs for fertility treatment or assisted reproduction procedures.
Related benefit information	• For shots or devices from your provider, see ***Preventive Care.*** • For coverage related to medical equipment and supplies, see ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies.*** • For Blood or blood derivatives coverage, see ***Blood Products and Services.*** • See ***Infusion Therapy*** for solutions and drugs that you get through a shot, intravenous needle, catheter, or a feeding tube. • To learn more about what experimental or investigational means, see ***Definitions.*** • Certain drugs need prior approval. See ***Prior Authorization***.

Getting Your Prescriptions Filled

Pharmacy	Supply Limit	What to do
In-network retail or specialty pharmacies	30 days at a time	Pay the amount you're responsible for at the pharmacy **Maintenance Drugs** The plan requires that you refill maintenance drugs at the in-network mail-order pharmacy. By doing this, you can save money on your prescriptions and get a greater supply of the drug. If you are currently taking a maintenance drug, you will be notified of the mail-order requirement. The plan will cover only 2 more refills of the drug at a retail pharmacy. This gives you plenty of time to get your prescription set up with the in-network mail order pharmacy. At your third refill at a retail pharmacy, you will be required to pay the full cost of the drug.
In-network mail-order pharmacy	90 days at a time	Ask your provider to prescribe up to a 90-day supply **Fill your prescription one of three ways:** • Download the "Home Delivery Order Form" on premera.com and send via mail • Call Premera HMO customer service at 1-800-722-4661 (TTY:711) • Sign in to **premera.com** go to: → Prescriptions, then → Manage prescriptions, then → Order and refill Allow 2 weeks for your prescription to be filled Maintenance drugs must be refilled at the in-network mail-order pharmacy to be covered under this plan. You will be notified if you are taking a maintenance drug.

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

Additional Information

Off-label Use

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

- 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.
- The Federal Secretary of Health and Human Services.

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).

Note: 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.

Prescription Drug Formulary

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

- The formulary includes both generic and brand name drugs. Consult the Pharmacy Benefit Guide or Formulary Guidebook listed on our website or contact customer service for a complete list of your plan's covered prescription drugs.
- Drugs not included in the formulary are not covered by this plan.

Generic Drug Substitution

This plan requires the use of appropriate generic drugs (as defined below). When available, a generic drug will be dispensed in place of a brand name drug. If there is no generic equivalent, you pay only the applicable brand name cost-share. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, 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 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 brand name drug instead of a generic equivalent without a penalty. To waive the penalty, your provider must show that 1 of 3 things is true:

- You cannot tolerate the generic equivalent drug
- The drug is not safe or effective for your condition
- The dosage you need is not available in a generic equivalent drug.
- If your request is approved, you pay only the applicable brand name cost-share. If your request is not approved and you choose to purchase the brand name drug, you will pay the penalty described under ***Generic Drug Substitution*** above

Exceptions Request for Non-Formulary Drugs

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

- There is no formulary drug or alternative available.
- You cannot tolerate the formulary drug.

- The formulary drug or dose is not safe or effective for your condition.

How to request an Exception

1) Your provider must give us a written or oral statement providing a justification in support of the need for the non-formulary drug to treat your condition, including a statement that all covered formulary drugs on any tier will be (or have been) ineffective, and would not be as effective as the non-formulary drug, or would have adverse side effects.

2) We will review your request and let you or your provider know within 72 hours in writing if it is approved. If approved, your cost will be as shown on the ***Covered Services*** for formulary drugs and will be covered for the duration of the prescription. If your request is not approved and you choose to purchase the non-formulary drug, the drug will not be covered.

Expedited Exceptions Request for Non-Formulary Drugs

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

External Review for Non-Formulary Drugs

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

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

Pharmacy Management

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

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

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

Dispensing Limits

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

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

Using In-network Pharmacies
When you use an in-network pharmacy, always show your Premera HMO ID Card. As a member, you will not be charged more than the allowed amount for each prescription or refill. The pharmacy will also submit your claims to us. You only have to pay the deductible, copay or coinsurance as shown in the ***Covered Services*** section.

If you do not show your Premera HMO ID Card, you will be charged the full retail cost. Then you must send us your claim for reimbursement. Reimbursement is based on the allowed amount. See ***How Do I File A Claim?*** for instructions.
This plan does not cover prescription drugs from out-of-network pharmacies.

Specialty Pharmacy Programs
The Specialty Pharmacy Program includes drugs that are used to treat complex or rare conditions. These drugs need special handling, storage, administration, or patient monitoring. This plan covers these drugs as shown in the ***Covered Services*** section

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

To find our in-network specialty pharmacies, visit the pharmacy section of our website at premera.com or call customer service for more information.

Drug Discount Programs
Premera HMO may receive drug rebates or discounts.

- Your benefit programs include per-claim rebates that Premera HMO receives from its pharmacy benefit manager or other vendors. We consider these rebates when we set the subscription charges, or we credit them to administrative charges that we would otherwise pay. These rebates are not reflected in your allowed amount.
- We also may receive discounts from our pharmacy benefit manager or other vendors. These discounts are reflected in your allowed amount. If the allowed amount for prescription drugs is higher than the price we pay after our discount, then Premera HMO does one of two things with this difference:
- We keep the difference and apply it to the cost of our operations and the prescription drug benefit program.
- We credit the difference to premium rates for the next benefit year.
- If your benefit includes a copay, coinsurance calculated as a percentage, or a deductible, the amount you pay and your account calculations are based on the allowed amount.

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

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Question	Answer
Does this plan exclude certain drugs my health care provider may prescribe, or encourage substitution for some drugs?	Your prescription drug benefit uses a drug list. (This is sometimes referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the prescription drug formulary. This plan doesn't cover certain categories of drugs. These are listed above under "What's Not Covered." Non-formulary medications may be covered only on an exception basis for members meeting medical necessity criteria. Certain formulary drugs are subject to pre-dispensing medical necessity review. As part of this review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent medication. See ***Prior Authorization*** for details.
When can my plan change the prescription drug formulary? If a change occurs, will I have to pay more to use a drug I had been using?	The formulary is updated frequently throughout the year. See "Prescription Drug Formulary" above. If changes are made to the drug list prior to the quarterly update, you will receive a letter advising you of the change that may affect your cost share.
What should I do if I want a change from limitations, exclusions, substitutions, or cost increases for drugs specified in this plan?	The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can't be changed. Provisions regarding substitution of some drugs are described above in question 1. You can appeal any decision you disagree with. Please see ***Complaints and Appeals*** or call our customer service department at the telephone numbers listed in ***Contact Information*** for information on how to initiate an appeal.
How much do I have to pay to get a prescription filled?	The amount you pay for covered drugs dispensed by a retail pharmacy, mail-order pharmacy or specialty pharmacy is described in the ***Covered Services*** section.
Do I have to use certain pharmacies to pay the least out of my own pocket under this plan?	Yes. You only receive benefits when you have your prescriptions filled by in-network pharmacies. The majority of pharmacies in Washington are part of our pharmacy network. 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 Premera HMO ID card.
How many days' supply of most medications can I get without paying another copay or other repeating charge?	The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the mail-order pharmacy benefit are described in the "Dispensing Limit" provision above. Benefits for refills will be provided only when the member has used 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.

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 in-network pharmacy. Other services, such as diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Preventive Care

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

Services are considered preventive when recommended or required by:

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

Visit **healthcare.gov** for more information.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Screening tests	No limit	No charge	Not covered
Colon cancer screening	No limit	No charge	Not covered
Wellness exams	No limit	No charge	Not covered
Birth control and tubal ligation	No limit	No charge	Not covered

Nutritional counseling and therapy	No limit	No charge	Not covered
Immunizations in the provider's office	No limit	No charge	Not covered
Seasonal immunizations at a pharmacy or mass immunizer location	No limit	No charge	No charge
Travel immunizations at a travel clinic or county health department	No limit	No charge	No charge
Health education and training (outpatient)	No limit	No charge	Not covered
Nicotine habit-breaking programs	No limit	No charge	Not covered

Benefit Overview

What services are included?

Wellness exams, including those for school, sports, and jobs

Screening tests and imaging, such as:

- Mammograms (including 3-D).
- Pap smears.
- Prostate-specific antigen tests.
- BRCA genetic tests for women at risk for certain breast cancers.
- Diabetes screening.

Colon cancer screening (for high-risk individuals and all individuals 45 years of age or older):

- Pre-colonoscopy consultation and exam.
- Colonoscopies as follow-up to a positive non-invasive stool-based screening test
- Barium enema.
- Colonoscopy, sigmoidoscopy, and fecal occult blood tests.
- If polyps are found during the screening, their removal and lab tests are covered as preventive.
- Medically necessary anesthesia.

Birth control and tubal ligation:

- Birth control devices, shots, and implants, including anesthesia.
- Plan B (emergency contraceptive).
- Tubal ligation (other services, like anesthesia, are covered as preventive only if tubal ligation is the primary procedure).

Routine maternity care:

- Routine prenatal exams and tests.
- Breastfeeding support and counseling.

	• Purchase of standard breast pump (bought from approved suppliers). **Call Premera HMO customer service for a list of approved suppliers**. • Rental of hospital-grade breast pump. Outpatient **nutritional counseling and therapy** for obese adults and children, and members at risk for health conditions affected by diet. **Immunizations**, including seasonal and for travel. **Pre-exposure (PrEP)** for members at high-risk for HIV infection. **Health education and training:** • Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma. • The program or class must take place in an approved setting, like a hospital. **Nicotine cessation programs.**
What is excluded? (Premera HMO pays 0%)	• Gym memberships/fees or exercise classes or programs. • Exams for insurance or work-related disability purposes. • Routine hearing exams. Routine or other dental care.
Related benefit information	• For tests and services to evaluate a sign, symptom or health, see ***Diagnostic, X-ray, Lab and Imaging.*** • See ***Prescription Drugs*** for take-home or over-the-counter items. • See ***Newborn Care*** for routine newborn exams when the child is in the hospital after birth. • If tubal ligation is a secondary procedure, it is still covered as preventive. However, related services like anesthesia are covered under the primary procedure. See ***Hospital*** and ***Surgery.*** • For vasectomy, see ***Surgery.***

Professional Visits and Services

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

Important things to know:
You can get care:

- At a provider's office or other medical setting.
- At home, when medically necessary.
- Virtually (secure chat, text, voice or video).

You can get virtual care two ways. What you pay depends on whether you:

- Schedule a virtual visit with an office-based provider (you'll pay for an office visit), or
- Use a Premera-designated app to get care (see ***App-based Care***) **Call Premera HMO for a list of covered apps.**

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	What will I pay? Out-of-network
Primary Care office and clinic visits (including virtual care)	No limit	$10 copay, deductible waived	Not covered
Office visits for women's health (e.g. gynecologist)	No limit	$10 copay, deductible waived	Not covered
All other professional office and clinic visits (including specialists)	No limit	$65 copay, deductible waived	Not covered

Benefit Overview

What services are included?	• Care by a qualified provider to examine, diagnose, or treat illness or injury. • Second opinions for any covered medical diagnosis or treatment plan.
What is excluded? (Premera HMO pays 0%)	• Hair analysis or non-prescription medicines, such as herbal, naturopathic or homeopathic medicines or devices. • EEG biofeedback or neurofeedback services.
Related benefit information	• For preventive services like wellness exams, see ***Preventive Care***. • For surgical procedures performed in a provider's office, surgical suite or other facility, see ***Surgery***. • For mental health conditions, see **Mental Health Care.** • Facilities may be billed separately, see ***Hospital***. • Lab tests or images may be billed separately, see ***Diagnostic X-Ray, Lab, And Imaging***. • See ***Home Health Care*** and ***Hospice Care*** for care in those settings.

Psychological and Neuropsychological Testing

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Psychological and Neuropsychological testing	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Rehabilitation Therapy

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

Important things to know:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Outpatient care	25 visits / year	$$65 Copay copay, deductible waived	Not covered
Inpatient care	30 days / year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	**Inpatient Care is covered when:** • It's medically necessary and you cannot get these services in a less intensive care setting. • Provided by a specialized inpatient rehab center (this could be part of a hospital). • The care is part of a written treatment plan prescribed by your provider. **Outpatient Care is covered for:** • Physical, speech, hearing, and occupational therapies, assessments, and evaluations related to rehab. • Cochlear implants. • Home medical equipment, medical supplies, and devices.
Whose services are covered?	• Physical therapist. • Occupational therapist. • Speech language pathologist. • Any other licensed provider practicing within the scope of their license.

What is excluded? (Premera HMO pays 0%)	• Treatment that the ill, injured, or impaired member does not actively take part in. • Therapy for flat feet except to help you recover from surgery to correct flat feet.
Related benefit information	• For services related to a mental health condition, see ***Mental Health Care***. • Chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases are covered as any other medical condition and do not accrue to rehabilitation therapy limits. • If you are using ***Neurodevelopmental (Habilitation) Therapy*** for the same treatment reason, this benefit can't be applied at the same time. Once the maximum has been met for either, no additional benefits are available.

Skilled Nursing Facility Care

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Skilled nursing facility care	90 days / year	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Substance Use Disorder

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	$10 copay, deductible waived	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered
Inpatient care and residential facility care	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

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

Surgery

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Surgery	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient professional services	No limit	Deductible, then 20% coinsurance	Not covered
Outpatient surgical center facility	No limit	Deductible, then 20% coinsurance	Not covered
Vasectomy	No limit	No charge	Not covered

Benefit Overview

What services are included?

- Surgical services, including injections, when performed on an inpatient or outpatient basis.
- Vasectomy.
- Anesthesia or sedation.
- Medically necessary postoperative care.
- Transfusion of blood or blood derivatives (storage is covered only when medically necessary).
- Correction of functional disorders.
- Cochlear implants.
- Cornea transplantation, skin grafts, and repair of a dependent child's congenital anomaly.
- Medically necessary surgery to correct the cause of infertility. This doesn't include assisted reproduction techniques or sterilization reversal.
- Diagnostic colonoscopy and sigmoidoscopy services not covered under ***Preventive Care***.

	• Biopsies and scope insertion procedures such as endoscopies. • Reconstructive surgery that is needed because of an injury, infection or other illness. • Sexual reassignment surgery if medically necessary. • Outpatient surgical center services and supplies.
Whose services are covered?	• Hospital. • Ambulatory surgical centers. • Surgical suite. • Provider's office. • Services provided by a surgeon.
What is excluded? (Premera HMO pays 0%)	• Removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss. • The use of an anesthesiologist for monitoring and administering general anesthesia for endoscopies, colonoscopies and sigmoidoscopies unless medically necessary when specific medical conditions and risk factors are present. • Cosmetic surgery.
Related benefit information	• See ***Mastectomy and Breast Reconstruction*** for those covered services. • For preventive colonoscopy benefits, see ***Preventive Care.*** • For gender affirming surgery benefits, see ***Gender Affirming Care***. • For organ, bone marrow, or stem cell transplant procedure benefits, see ***Transplants.*** • See ***Hospital*** for your facility cost share amounts.

[Temporomandibular Joint Disorders Care (TMJ)]

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

Important things to know:

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

Examples of symptoms linked with TMJ include:

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

Cost Overview

What is covered?	What is the limit?	What will I pay?	
		In-network	Out-of-network
Office and clinic visits	No limit	$10 copay, deductible waived	Not covered
All other professional office and clinic visits (including specialists)	No limit	$65 copay, deductible waived	Not covered
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

What services are included?	• Consultations. • Exams. • Treatment.
What's excluded? (Premera HMO pays 0%)	• A bite guard is not covered.
Related benefit information	• Most TMJ services require prior authorization before you get them. See ***Prior Authorization*** for details.

Additional Information

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

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

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

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

Therapeutic Injections

Therapeutic injections and related supplies to relieve pain and treat medical conditions when provided in a provider's office.

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Therapeutic Injections	No limit	Deductible, then 20% coinsurance	Not covered

Benefit Overview

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

Transplants

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

Important things to know:

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

Cost Overview

What is covered?	What is the limit?	What will I pay? In-network	Out-of-network
Office and clinic visits	No limit	See Professional Visits and Services	Not covered*
Inpatient facility care	No limit	Deductible, then 20% coinsurance	Not covered*
Other professional services	No limit	Deductible, then 20% coinsurance	Not covered*

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

Benefit Overview

What services are included?	**Organ transplants and bone marrow/stem cell reinfusion procedures covered:** • Heart. • Heart/double lung. • Single/double lung. • Liver. • Kidney. • Pancreas. • Pancreas with kidney. • Bone marrow (autologous and allogeneic.) • Stem cell (autologous and allogeneic). **Transplant Recipient** • Transplant and reinfusion related expenses, including preparation. • Anti-rejection drugs administered by the transplant center during inpatient or outpatient stay.

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

Additional Information

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

Urgent Care

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

Important things to know:

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

Cost Overview

 What is covered?	 What is the limit?	 What will I pay? In-network	Out-of-network
Freestanding urgent care centers (including in-home visit)	No limit	$25 copay, deductible waived	$25 copay, deductible waived
Urgent care centers attached to, or part of a hospital	No limit	$300 copay, deductible, then 20% coinsurance	$300 copay, in-network deductible, 20% coinsurance

Benefit Overview

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

Exclusions & Limitations

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

Benefit or Service	Exclusion
Amounts over the Allowed Amount	Costs over the allowed amount as defined by this plan for a non-emergency service from an out-of-network provider.
Assisted Reproduction	Assisted reproduction technologies, including but not limited to: • Drugs to treat infertility or that are required as part of assisted reproduction procedures. • Artificial insemination or assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure. • Services to make you more fertile or for multiple births. • Reversing sterilization surgery.
Benefits from Other Sources	Services that are covered by liability insurance, motor vehicle insurance, excess coverage, no fault coverage, workers compensation or similar coverage for work-related conditions. For details see *Third Party Recovery* under *What If I have Other Coverage.*
Benefits that have been exhausted	Services that in excess of limitations or maximums of this plan.
Charges for broken or missed appointments	Charges from providers for broken or missed appointments.
Charges for records or reports	Charges from providers for supplying records or reports that aren't requested by Premera HMO for utilization review.
Comfort or Convenience	• Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting. • Normal living needs, such as food, clothes, housekeeping, and transport. This doesn't apply to chores done by a home health aide as prescribed in your treatment plan. • Dietary assistance, including "Meals on Wheels".
Complications	Complications of a non-covered service, including follow-up services or effects of those services.
Cosmetic Services	Drugs, services, or supplies for cosmetic services that are not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.
Counseling, Education and Training	Counseling, 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	Services that you must get to avoid being tried, sentenced, or losing the right to drive when they are not medically necessary.
Custodial Care	This plan does not cover custodial care.

Dental Care	This plan does not cover dental care.
Environmental Therapy	Therapy designed to provide a changed or controlled environment.
Experimental or Investigative Services	Any service or supply that is experimental or investigative; see *Definitions*.
Family Members or Volunteers	Services or supplies that you provide to yourself. It also doesn't cover a provider who is: • Your spouse, mother, father, child, brother, or sister. • Your mother, father, child, brother, or sister by marriage. • Your stepmother, stepfather, stepchild, stepbrother, or stepsister. • Your grandmother, grandfather, grandchild, or their spouse. • A volunteer.
Governmental Facilities	Services provided by a state or federal facility that are not emergency services or required by law or regulation.
Hair Analysis	Analysis for any reason.
Hair Loss	• Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth. • Hair transplants and implants.
[Hearing Exams	Hearing exams and testing used to prescribe or fit hearing aids and any associated service or supply.]
[Hearing Hardware	Hearing aids and devices used to improve hearing sharpness and any associated service or supply.]
Illegal Acts, Illegal Services, and Terrorism	Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.
Laser Therapy	Low-level laser therapy.
Military Service and War	Illness or injury that is caused by or arises from: • Acts of war, such as armed invasion, no matter if war has been declared or not. • Services in the armed forces of any country, including any related civilian forces or units.
Non-Covered Services	Services or supplies directly related to any non-covered condition. • Ordered when this plan is not in effect or when the person is not covered under this plan. • Provided to someone other than the ill or injured member. • That are not listed as covered under this plan. • Services and supplies that you are not legally required to pay. • Non-treatment charges, including charges for provider time. • Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.
Non-Treatment Charges	• Charges for provider travel time • Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. • Housework or chores for the member.
Non-Treatment Facilities, Institutions or Programs	Benefits are not provided for: • Institutional care. • Housing. • Incarceration.

	• Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, and juvenile detention facilities.
Not Medically Necessary	Services or supplies that are not medically necessary even if they're court ordered.
Orthodontia	Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.
Provider's Licensing Certification	Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified providers.
Recreational, Camp and Activity Programs	Recreational, camp and activity-based programs. These programs are not medically necessary and include: • Gym, swim and other sports programs, camps, and training. • Creative art, play and sensory movement and dance therapy. • Recreational programs and camps. • Boot camp programs, outward bound programs and tall-ship programs. • Equine programs and other animal-assisted programs and camps. • Exercise and maintenance-level programs. • Hiking, and other adventure programs and camps.
Serious Adverse Events and Never Events	Serious Adverse Events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge. Never Events are events that should never occur, such as a surgery on the wrong patient, surgery on the wrong body part or a wrong surgery. Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-Network providers may not bill members for these services and members are held harmless. Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at 1-800-722-4661 (TTY:711) or on the Center for Medicare and Medicaid Services (CMS) website.
Services or Supplies For Which You Don't 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 hypoactive sexual desire disorder, including drugs, medications, or penile or other implants.
[Vision Exam	Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.]
[Vision Hardware	Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies not 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.]

Voluntary Support Group	Patient support, consumer, or affinity groups such as diabetic support group or Alcoholics Anonymous.
Weight Loss Surgery or Drugs	Surgery, drugs or supplements for weight loss or weight control, even if you have an illness or injury that might be helped by weight loss surgery or drugs.
Work-Related Illness or Injury	Any illness, condition, or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see ***Third Party Recovery*** under ***What If I have Other Coverage***.

Other Coverage?

COORDINATING BENEFITS WITH OTHER HEALTH PLANS

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

If you do not know which plan 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 purpose of COB:

Term	Definition
Plan	• A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contact or benefit to which COB doesn't apply is treated as a separate plan. • "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law. • "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law. • **This plan** means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your Premera Blue Cross HMO plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.
Primary Plan	Primary plan is a plan that provides benefits as if you had no other coverage.
Secondary Plan	Secondary plan is a plan that can reduce its benefits in accordance with COB rules. See ***COB's Effect on Benefits*** later in this section for rules on secondary plan benefits.
Allowable Medical Expense & Allowable Dental Expense	The usual, customary, and reasonable charge for any medically or dentally necessary service provided by a licensed medical or dental professional when the service is covered at least in part under this plan.

	When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered, or supply provided will be considered an allowable expense. For the purposes of this plan, only dental services to treat an injury to natural teeth will be considered an allowable dental expense.
Custodial Parent	The parent awarded custody by a court decree. In the absence of a court decree, the parent with whom the child lives with for more than half of the calendar year, excluding any temporary visitation.
Gatekeeper Requirements	Gatekeeper requirements are any requirements that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. Examples are restrictions of coverage to providers in a network, prior authorization, or primary care provider referrals.

HOW THIS AFFECTS BENEFITS

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first, this is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary.

When this plan is secondary, it will reduce its benefits for each claim so that the benefits from all medical plans aren't more than the allowable medical expense for that claim and the benefits from all dental plans aren't more than the allowable dental expense for that claim.
We'll coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

PRIMARY AND SECONDARY RULES

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

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

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

Non-Dependent or Dependent	The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.
Dependent Children	Unless a court decree states otherwise, the rules below apply: • **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary. **When the parents are divorced, separated, or not living together, whether or not they were ever married:** • If a court decree makes one parent responsible for the child's 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, the plan of the parent with financial responsibility is primary. • Makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary. • 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.
TRICARE	If you are a member of the U.S. military (active or retired) or you have dependents enrolled in the TRICARE program, this plan is the primary plan and TRICARE would be secondary, when required by federal law.
Continuation Coverage	If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that is not through COBRA or other continuation law. **Please Note**: The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.
Length of Coverage	The plan that covered you longer is primary to the plan that didn't cover you as long. If none of the rules above apply, the plans must share the allowable expenses equally.

COB'S EFFECT ON BENEFITS

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

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

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

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

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

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

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

Right of Recovery/Facility of Payment

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

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

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

Third Party Recovery

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

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

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

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

Note: For this section, a third party doesn't include other health care plans that cover you.

DEFINITIONS

The following definitions apply to this section:

Term	Definition
Injury	An injury or illness that a third party is or may be liable for.
Recovery	All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgement, award, or settlement.

	It doesn't matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amount put into a trust or constructive trust set up by or for you or your family, beneficiaries, or estate as a result of your injury.
Reimbursement Amount	The amount of benefits paid by the plan for your injury that you must pay back to the plan out of any recovery per the terms of this section.
Responsible Third Party	A third party that is or may be responsible under the law ("liable") to pay you back for your injury.
Third Party	A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers' compensation coverage. The third party may not be the actual party who caused the injury and may include an insurer.
You	In this section, "you" includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

Benefits From Other Sources

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

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

Work-Related Illness or Injury

This plan doesn't 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

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

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.

If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits. The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer, or your estate. The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.

The plan's right to reimbursement first and in full shall apply even if:

- The recovery is not enough to make you whole for your injury
- The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
- The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
- The member is a minor, disabled person, or isn't able to understand or make decisions.
- The member didn't make a claim for medical expenses as part of any claim or demand
  - Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
  - In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must cooperate with the plan as it pursues its claim.
  - The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
  - You cannot assign any rights or causes of action that you might have against a third-party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

You must notify Premera Blue Cross HMO of the injury immediately and no later than 30 days of any claim for the injury.

You must notify the third parties of the plan's rights under this provision

You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.

If you hire a lawyer, you must tell Premera Blue Cross HMO right away and provide the contact information.

Neither the plan nor Premera Blue Cross HMO shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify, and hold the plan and Premera Blue Cross HMO harmless from any claims from your lawyer for lawyer's fees or costs.

You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

Claims for your injury will not be paid until Premera Blue Cross HMO receives a completed copy of the Incident Questionnaire when one was sent.

You must tell Premera Blue Cross HMO if you have received recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.

You must notify the plan at least 14 days prior to any settlement, trial, or other material hearing concerning the suit or claim.

If any of the requirements above are not met, the plan shall:

- Deny or delay claims related to your injury
- Recoup directly from you all benefits the plan has provided for your injury
- Deduct the benefits owed from any future claims

Reimbursement and Subrogation Procedures

If you receive a recovery, you or your lawyer shall hold the recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the plan's reimbursement rights have been determined you shall make immediate payment to the plan out of the recovery proceeds.
If you or your lawyer don't promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount.

Such action shall include, but not be limited to one or both of the following:

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

How Do I File a Claim?

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

Medical Claims

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

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

Step 3. **Send in my claim**	To help process your claim, the form must be fully completed, signed, and returned with all required documents. Send your documents one of two ways: • **Email through your Secure Inbox** Sign into your account at premera.com and select Secure Inbox. Scan and send the completed form and any required documents back to us as a secure email attachment. • **Mail to** Premera Blue Cross HMO PO Box 327 Seattle, WA 98111-0327 **Note:** Any highlights or modifications to your bill may delay processing your claim.

Prescription Drug Claims

In-Network Pharmacies	**For retail pharmacy purchases:** • Show your Premera Blue Cross HMO member ID card to the pharmacist and they will bill us directly. • If you don't show your member ID card, you'll have to pay the full cost of the prescription and submit the claim yourself. **For mail-order pharmacy purchases:** • Follow the instructions on the order form and submit it to the address on the form. Please allow up to 14 days for delivery. If you need an in-network mail-order pharmacy order form, contact Premera HMO customer service at 1-800-722-4661 (TTY:711)
Coordination of Prescription Claims	• Complete a Prescription Drug Claim Form and attach any receipts. • Send the form with all required documents to the address on the form. If you need a Prescription Drug Claim Form contact Premera HMO customer service at 1-800-722-4661 (TTY:711)
Where do I send my claim?	**Questions?** Contact our pharmacy benefit manager, Express Scripts at: • 1-800-391-9701 • Or visit express-scripts.com **Mail your prescription drug claims to:** Express Scripts ATTN: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711

Timely Filing

We must receive claims:

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

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

Special Notice About Claims Procedure

We process claims in the order received and will make every effort to process your claims as quickly as possible. Within 30 days of receiving a claim, we'll send you a written notice letting you know if this plan will cover all or part of the claim. We can extend the time limit up to 15 days if more time is needed due to matters beyond our control. If we do need more time, we'll let you know before the 30-day time limit ends.

If more information is needed to help decide your claim, we'll reach out to you or your provider. You or your provider will have at least 45 days to send us the information. The time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information needed, we have 15 days to give you our decision.

If all or part of your claim was denied, our written notice(s) will include:

- The reason(s) for the denial and a reference to the provisions of this plan on which it's based.
- A description of any additional information needed to reconsider the claim and why it's needed.
- Any clinical reason for the denial, if applicable, in a letter stating these reasons.
- A statement that you have the right to appeal our decision.
- A description of the plan's complaint and appeal process.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, friend or a relative. You must notify us in writing and give the name, address, and telephone number where your appointee can be reached.
If all or part of your claim is denied you may send us a complaint or appeal as outlined under the ***Complaints and Appeals*** section.
If all or part of a claim or an appeal is denied, ignored, or not processed within the time shown in this plan, you may file suit in a state or federal court.

Additional Information

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

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

If you only had to pay a copay to your provider for a covered service, that is not considered a claim for benefits. To get a paper copy of an explanation of benefits call customer service at 1-800-722-4661 (TTY: 711). Or you can visit premera.com for secure online access to your claims.

NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIMS

At our option and in accordance with federal and state law, we may pay the benefits of this plan to the eligible member, provider, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge our obligation to the extent of the amount paid so that we will not be liable to anyone aggrieved by our choice of payee.

CLAIM PROCEDURE FOR GROUPS SUBJECT TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

We will make every effort to review your claims as quickly as possible. We process claims in the order in which we receive them.

We will send a written notice to you no later than 30 days after we receive your claim to let you know if your plan will cover all or part of the claim.

If your claim is denied, in whole or in part, our written notice (see ***Notice***) will include:

- The reasons for the denial and a reference to the plan provisions used to decide your claim.
- A description of any additional information needed to reconsider your claim and why the information is needed.
- A statement that you have the right to submit a complaint or appeal.
- A description of the plan's complaint or appeal processes.

If there were clinical reasons for the denial, you will receive a letter from us stating these reasons.

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

If all you have to pay is a copay for a covered service or supply, it is not a claim for benefits. You can call customer service to get a paper copy of an Explanation of Benefits for the service or supply. The phone number is in ***Contact Information*** and on your Premera HMO ID card. Or, you can visit our website, premera.com, for information and secure online access to claims information. To file a claim, please see ***How Do I File A Claim?*** for more information.

If your claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals.***

Complaints and Appeals

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

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

WHAT IS A COMPLAINT?

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

How to file a complaint

Call customer service at 800-722-4661 (TTY:711)

Send a fax to 425-918-5592

Send the details in writing to:
Premera Blue Cross HMO
PO Box 91102
Seattle, WA 98111-9202

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

WHAT IS AN APPEAL?

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

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

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

WHAT YOU CAN APPEAL

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits
	Denied	Coverage of your service, supply, device, or prescription was denied or partially denied. This includes prior authorization denials.

APPEALS LEVELS

You have the right to two levels of appeals:

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

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. Get the form	• Complete the **Member Appeal Form**, you can find it on premera.com or call customer service to request a copy. If you need help filing out an appeal, or would like a copy of the appeals process, call customer service at 800-722-4661 (TTY:711)
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on premera.com. We can't release your information without this form.
Step 3. Send in my appeal	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross HMO Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 **Fax to** 425-918-5592

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

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

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

Appeal Response Time Limits

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

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

IF WE NEED MORE TIME

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

WHAT IF YOU HAVE ONGOING CARE?

Ongoing care is continuous treatment you're 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 doesn't 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 IF IT'S URGENT?

If your condition is urgent, you will get your response sooner. Urgent appeals are only available for services you are currently receiving or haven't yet received.

Examples of urgent situations are:

- Your life or health is in serious danger, or 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're requesting coverage for inpatient or emergency services that you're currently receiving

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

HOW TO ASK FOR AN EXTERNAL REVIEW

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

Step 1. Get the form	**We'll tell you about your right to an external review with the written decision of your internal appeal.** • Complete the Independent Review Organization (IRO) Request form, you can find it on premera.com or call customer service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. Collect supporting documents	• Collect any supporting documents that may help with your external review This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
Step 3. Send in my external review request	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross HMO Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202

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

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

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and Premera HMO immediately after a decision has been made. Premera HMO will accept the IRO decision on behalf of the plan.

If the IRO:

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

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

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

1-800-562-6900

E-mail: **cap@oic.wa.gov**

You can also contact the Employee Benefits Security Administration of the U.S. Department of Labor at 1-866-444-EBSA (3272).

Eligibility And Enrollment

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

Subscriber

To be a subscriber under this plan, you must meet all of the requirements listed below. You must:

- Be a regular and active employee, owner, partner, or corporate officer of the Participating Employer who is paid on a regular basis through the Participating Employer's payroll system, and reported by the Participating Employer for Social Security purposes
- Regularly work the minimum hours required by the Participating Employer
- Satisfy any probationary period, if one is required by the Participating Employer.

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

Dependents

To be a dependent under this plan, the family member must be:

- The lawful spouse of the subscriber, unless legally separated ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction). However, if the spouse is an owner, partner, or executive officer of the Participating Employer, the spouse is eligible to enroll only as a subscriber.

- The Subscriber's state-registered domestic partner (as required by Washington state law) or if specifically included as eligible by the Participating Employer, the Subscriber's non-state registered domestic partner.
- An eligible child who is under 26 years of age, except as provided for in the ***Continued Eligibility for a Disabled Child*** provision.

  An eligible child is one of the following:

  - A natural offspring of either or both the subscriber or spouse
  - A legally adopted child of either or both the subscriber or spouse
  - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
  - A legally placed dependent or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

ENROLLMENT IN THE PLAN

The subscriber must enroll on forms provided and/or accepted by us. To obtain coverage, a subscriber must enroll within 60 days after becoming eligible. Enrollment after this initial time period can be accomplished as outlined under ***Open Enrollment*** and ***Special Enrollment***.

Dependent enrollment and payment of any necessary additional subscription charges must occur within 60 days from the date of marriage or date of registered domestic partnership, birth or placement. Enrollment after this initial time period can be accomplished as outlined under ***Open Enrollment*** and ***Special Enrollment***.

Newborn Child	Newborn children are covered automatically for the first 3 weeks from birth. To extend the child's coverage beyond the 3-week period, the subscriber should follow the steps below. If the child qualifies as an eligible dependent, the subscriber should follow the steps below to enroll the child from birth. • An enrollment application isn't required for natural newborn children when subscription charges being paid already include coverage for the new dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for natural newborn children on the date of birth. • When subscription charges being paid don't already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us by the Participating Employer within 60 days following birth. Coverage becomes effective from the date of birth. If we don't receive the enrollment application within 60 days of birth, the child can't enroll until the next open enrollment period. See ***Open Enrollment*** later in this section. Enrollment after this initial time period can be accomplished as outlined under ***Open Enrollment*** and ***Special Enrollment***.
Adoptive Children	• An enrollment application isn't required for adoptive children placed with the subscriber when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for adoptive children on the date of placement with the subscriber. • When subscription charges being paid don't already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us within 60 days following the date of placement with the subscriber. Coverage becomes effective from the date of placement. If we don't receive the enrollment application within 60 days of the date of placement with the subscriber, the child can't enroll until the next open enrollment period. See ***Open Enrollment***.
Legal Guardianship	A legally placed dependent or foster child is added when we receive the completed enrollment application, any required subscription charges, and a copy of the court or other order (signed by a judge or other state agency) within 60 days. Coverage for an eligible legal ward or foster child will begin on the date legal guardianship began. If we don't receive the enrollment application within 60 days of the date legal guardianship began, the child can't enroll until the next open enrollment period. See ***Open Enrollment***.
Medical Child Support	When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid or the state child support enforcement agency. When subscription charges being paid do not already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Participating Employer for detailed procedures.

SPECIAL ENROLLMENT

The plan allows employees and dependents who didn't enroll when they were first eligible or at the plan's last open enrollment period to enroll outside the plan's annual open enrollment period only in the cases listed below.

If we don't receive a completed enrollment application within the time limits stated below. See ***Open Enrollment***.

Involuntary Loss of Other Coverage	If an employee and/or dependent doesn't enroll in this plan or another plan sponsored by the Group when first eligible because they aren't required to do so, that employee and/or dependent may later enroll in this plan and continue receiving coverage if previously enrolled, outside of the annual open enrollment period if each of the following requirements is met:
	• The employee and/or dependent was covered under Participating Employer health coverage or a health insurance plan at the time coverage under the Group's plan is offered.
	• The employee and/or dependent's coverage under the other group health coverage or health insurance plan ended as a result of one of the following:
	  • Loss of coverage purchased through the Exchange, due to an error by the Exchange, the insurer, or Health and Human Services (HHS).
	  • Loss of eligibility for Medicaid or a public program providing health benefits.
	  • A permanent change in residence, work, or living situation, where the prior health plan does not provide coverage in the new service area.
	  • Loss of eligibility for coverage for reasons including, but not limited to legal separation, divorce, death, termination of employment, or the reduction in the number of hours of employment, or plan no longer offers benefits to the class of similarly situated individuals.
	  • Termination of employer contributions toward such coverage.
	  • The employee and/or dependent was covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted.
	An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible employee isn't enrolled in any of the Group's plans or is enrolled in a different plan sponsored by the Group, the employee is also allowed to enroll in this plan in order for the dependent to enroll.
	We must receive the completed enrollment application and any required subscription charges from the Group within 60 days of the date such other coverage ended. When the 60-day time limit is met, coverage will start on the day after the last day of the other coverage.

Subscriber and Dependent Special Enrollment	An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under ***Enrollment in the Health Plan*** in the case of marriage, birth or adoption. The eligible employee may also choose to enroll without enrolling any eligible dependents or change plans, if applicable.
State Medical Assistance and Children's Health Insurance Program	Employees and dependents who are eligible as described in ***Eligibility and Enrollment*** have special enrollment rights under this plan if one of the statements below is true: • The person is eligible for state medical assistance, and the Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective to enroll the person in this plan • The person qualifies for premium assistance under the state's medical assistance program or Children's Health Insurance Program (CHIP) • The person no longer qualifies for health coverage under the state's medical assistance program or CHIP • The loss of coverage under a Student Insurance plan (involuntary or voluntary) • Experience an exceptional circumstance that prevented enrollment in coverage • Victims of domestic abuse/violence or spousal abandonment and their

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

OPEN ENROLLMENT

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

When you enroll for coverage under a different Participating Employer healthcare plan also offered by the Participating Employer, enrollment for coverage under this plan can only be made during the Participating Employer's open enrollment period.

CHANGES IN COVERAGE

Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

PLAN TRANSFERS

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

When we update the contract for this plan, or you transfer from the Participating Employer's other plan, and there's no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied and/or credited under the prior plan:

- Out-of-pocket maximum.
- Calendar year deductible. Please note that we will credit expenses applied to your prior plan's calendar year deductible **only** when they were incurred in the current calendar year. Expenses incurred during October through December of the prior year are not credited toward this plan's calendar year deductible for the current year.

Termination of Coverage

EVENTS THAT END COVERAGE

Coverage will end without notice (see ***Notice***) on the last day of the month for which subscription charges have been paid in which one of these events occurs:

For the subscriber and dependents when:

- The Group contract is terminated
- The next monthly subscription charge isn't paid when due or within the grace period
- The subscriber dies or is otherwise no longer eligible as a subscriber
- The Participating Employer’s membership in the association ceases
- In the case of a collectively bargained plan, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
- For a spouse when their marriage to the subscriber is annulled, or when they become legally separated or divorced from the subscriber

- For a child when they cannot meet the requirements for dependent coverage shown ***Dependents*** above.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. The Group must give us written notice (see ***Notice***) of a member's termination within 30 days of the date the Group is notified of such event.

In the event of termination of coverage, Premera HMO will allow special enrollment for employees and dependents under certain conditions (see ***Special Enrollment***).

CONTRACT TERMINATION

Termination of the Group Contract for this plan completely ends all members' coverage and all our obligations. See ***Continuation of Coverage*** below.

This plan is guaranteed renewable. However, this plan will automatically terminate if subscription charges aren't paid when due; coverage will end on the last day for which payment was made. This plan may also terminate as indicated below.

The **Group** may terminate the Group Contract:

- Effective on any subscription charge due date, upon 30 days' advance written notice (see ***Notice***)
- By rejecting in writing the contract changes we make after the initial term. The written rejection must reach us at least 15 days before the changes are to start. The Group Contract will end on the last date for which subscription charges were paid.

We may terminate the Group Contract, **upon 30 days advance written notice** (see ***Notice***) **to the Group if:**

- Fraud or other intentional misrepresentation of material fact is made by the Group, as explained in ***Other Information About My Plan.***
- The Group fails to meet the minimum participation or contribution requirements stated in its signed application.
- The Group no longer has any members who reside or work in Washington.
- Published policies, approved by the Office of the Insurance Commissioner, have been violated.
- There is a material breach of the Group Contract, other than nonpayment.
- Changes or implementation of federal or state laws that no longer permit the continued offering of this contract.
- We discontinue this contract, as allowed by law. In such instance we will give at least a 90-day notification of the discontinuation.
- We withdraw from a service area or from a segment of a service area, as allowed by law.
- We are otherwise permitted to do so by law.

Continuation of Coverage

There are specific requirements, time frames and conditions which must be followed in order to be eligible for continuation of coverage and which are generally outlined below. Please contact your employer/Participating Employer as soon as possible for details if you think you may qualify for continuation of coverage.

Continued Eligibility for a Disabled Child	Coverage may continue beyond the limiting age (see ***Dependent Eligibility***) for a child who cannot support themselves because of a developmental or physical disability. The child will continue to be eligible if all the following are met: • The child became disabled before reaching the limiting age. • The child is incapable of self-sustaining employment by reason of developmental or physical disability and is chiefly dependent upon the subscriber for support and maintenance. • The subscriber is covered under this plan. • The child's subscription charges, if any, continue to be paid. • Within 31 days of the child reaching the limiting age, the subscriber furnishes us with a Request for Certification of Disabled Dependent form. We must approve the request for certification for coverage to continue. • The subscriber provides us with proof of the child's disability and dependent status when we request it. We won't ask for proof more often than once a year after the 2-year period following the child's attainment of the limiting age.
Leave of Absence	Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

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

	member of the armed forces" also means a veteran who was discharged from the armed forces (other than a dishonorable discharge) at any time during the 5 years before the FMLA leave starts. The subscriber must pay their normal share of the subscription charges during the leave. The subscriber and some or all covered family members can choose not to stay on the plan during the FMLA leave. In that case, they can be enrolled again when the subscriber returns to work at the end of the FMLA leave. Coverage will start on the date the subscriber returns to work. If the subscriber does not return to work at the end of the FMLA leave, the subscriber and covered family members will have a right to elect COBRA coverage. The FMLA leave period does not count as part of the COBRA period. Eligible subscribers must give the Group 30 days advance notice when they know ahead of time that they need to take a leave of absence. This is only a summary of what FMLA requires. Please contact the Group to learn more about FMLA leaves. If the FMLA requirements change, this plan will comply with the changes. The Group must keep Premera Blue Cross HMO advised about the eligibility for coverage of any employee who may have a right to benefits under FMLA.
Labor Dispute	A subscriber may pay subscription charges through the Participating Employer to keep coverage in effect for up to 6 months in the event of suspension of compensation due to a lockout, strike, or other labor dispute.
For Participating Employers with 20 or More Employees	If you become ineligible you may continue coverage to the extent required by the federal Consolidated Omnibus Budget Reconciliation Act of 1986, (COBRA) as amended, and Washington state law. You may be eligible to continue coverage on a self-pay basis for 18 or 36 months through COBRA. COBRA is a federal law which requires most employers with 20 or more employees to offer continuation of coverage. How long you may continue coverage on COBRA will depend upon the circumstances which caused you to lose your coverage on the Participating Employer plan.
Three-Month Continuation of Participating Employer Coverage	You may choose to extend your coverage under this plan for up to 3 months past the date your coverage ended if: • Your Participating Employer isn't subject to COBRA. • You're not eligible for COBRA coverage. • Your Participating Employer coverage ends for reasons other than as described under ***Intentionally False or Misleading Statements.*** You must send your first subscription charge payment and completed application to the Participating Employer by the due date determined by the Participating Employer. The Participating Employer will in turn send us your subscription charge payment and completed application form with the first payment it makes on or after the date your coverage ended. Subsequent subscription charge payments must be paid to the Participating Employer, by the date determined by the Participating Employer, and forwarded to us by the Participating Employer with their regular monthly billings. Continued coverage under this plan may end before the 3-month period expires. It will end on the last day of the monthly period for which subscription charges have been paid in which the first of the following occurs: • The next monthly subscription charge is not paid when due or within the grace period. • The contract between the Participating Employer and us is terminated. **Please Note:** The three-month continuation period isn't available for those eligible for COBRA coverage once COBRA coverage is exhausted.

Converting to a Non-Participating Employer Plan	You may be entitled to coverage under one of our Individual plans when your coverage under this plan ends, in accordance with applicable state laws regarding conversion agreements. Individual plans differ from this plan. You pay the monthly payment. You must apply and send the first subscription charge payment to us within 31 days of the date your coverage ends under this plan or you were first notified that your coverage had ended under this plan, whichever is later. You can apply for an Individual plan if you live in Washington State and you're not eligible for Medicare coverage. For more information about Individual plans, contact your employer or our customer service department. **Please Note:** The rates, coverage and eligibility requirements of Individual plans differ from those of your current Participating Employer plan. In addition, enrollment in an individual plan may limit your ability to later purchase an individual plan.
Medicare Supplement Coverage	We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you **may** be eligible for guarantee-issued coverage under certain Medicare supplement plans if you apply within 63 days of losing coverage under this plan. For more information, contact your producer or our customer service department.

Other Plan Information

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

Benefit Modifications	From time to time, we may change the terms of this contract. You will receive prior written notice of any changes, and 30 days prior written notice of changes to subscription charges (see ***Notice***). If the terms of this contract change, those changes will not affect benefits to a member during confinement in a facility. Benefit changes will take effect when you leave the facility, or from any other facility you are transferred to, as long as you are still covered under this plan. No producer or agent of Premera HMO or any other person, is authorized to make any changes, additions, or deletions to this contract or to waive any provision of this contract. Changes, alterations, additions, or exclusions can only be done with the signature of an officer of Premera HMO.
Benefits Not Transferable	No person other than you is entitled to receive the benefits of this contract. Such right to these benefits is not transferable. Fraudulent use of such benefits will result in cancellation of your eligibility under this contract and appropriate legal action.
Conformity with the Law	The Group Contract is issued and delivered in the State of Washington and is governed by the laws of the State of Washington, except to the extent pre-empted by federal law. If any provision of the Group Contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Group Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.
Entire Contract	The entire contract between the Group and us consists of all of the following: • The contract face page and "Standard Provisions" • This benefit booklet(s) • The Group's signed application • All attachments, endorsements, and riders included or issued hereafter No representative of Premera Blue Cross HMO or any other entity is authorized to make any changes, additions or deletions to the Group Contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done with the signature of an officer of Premera Blue Cross HMO. If there is a language conflict in the contract, the benefit booklet (as amended by any attachments, endorsements or riders) will govern.
Evidence of Medical Necessity	We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you, or on your behalf by your healthcare providers. No benefits will be available if the proof isn't provided or acceptable to us.
The Group and You	The Group and the Participating Employer is your representative for all purposes under this plan and not the representative of Premera Blue Cross HMO. Any action taken by the Participating Employer will be binding on you.
Health Care Providers - Independent Contractors	All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this contract are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.
ID Card	If you need a replacement Premera HMO ID card, call our customer service or visit our website at premera.com If coverage under the contract terminates, your

	Premera HMO ID card will no longer be valid.
Intentionally False or Misleading Statements	If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, we'll be entitled to recover these amounts. Please see ***Right of Recovery*** later in this section. And, if a member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the member's acceptability for coverage, we may, at our option: • Deny the member's claim. • Reduce the amount of benefits provided for the member's claim. • Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all). Finally, statements that are fraudulent, intentionally false or misleading on any Group form required by us, that affect the acceptability of the Group or the risks to be assumed by us, may cause the Group Contract for this plan to be voided. **Please note:** We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.
Limitations of Liability	We are not legally responsible for any of the following: • Epidemics, disasters, or other situations that prevent members from getting the care they need. • The quality of services or supplies that members get from providers, or the amounts charged by providers. • Providing any type of hospital, medical, dental, vision, or similar care. • Harm that comes to a member while in a provider's care. • Amounts in excess of the actual cost of services and supplies. • Amounts in excess of this plan's maximums. This includes recovery under any claim of breach. • General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages.
Member Cooperation	You're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.
Newborn's and Mother's Health Protection Act	Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours).
Notice	We may be required to send you certain notices. We will consider such a notice to be delivered if we mail it to your most recent address in our records. The date of the postmark is the delivery date. If you are required to send notice to us, the postmark date will be the delivery date. If not postmarked, the delivery date will be the date we receive it.
Notice of Information Use and Disclosure	We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as

	your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources. This information is collected, used or disclosed for conducting routine business operations such as: • Determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.). • Coordinating benefits with other healthcare plans. • Conducting care management, case management, or quality reviews. • Fulfilling other legal obligations that are specified under the Group Contract. This information may also be collected, used or disclosed as required or permitted by law. To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it. If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization. You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our customer service department and ask a representative to mail a request form to you.
Notice of Other Coverage	As a condition of receiving benefits under this plan, you must notify us of: • Any legal action or claim against another party for a condition or injury for which we provide benefits; and the name and address of that party's insurance carrier. • The name and address of any insurance carrier that provides: • Personal injury protection (PIP). • Underinsured motorist coverage. • Uninsured motorist coverage. • Any other insurance under which you are or may be entitled to recover compensation. • The name of any other group or individual insurance plans that cover you.
Rights of Assignment	Notwithstanding any other provision in this contract, and subject to any limitations of state or federal law, in the event that we merge or consolidate with another corporation or entity, or do business with another entity under another name, or transfer this contract to another corporation or entity, this contract shall remain in full force and effect, and bind the subscriber and the successor corporation or other entity. We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.
Right of Recovery	We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us. In addition, if this contract is voided as described in ***Intentionally False or Misleading Statements***, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right to and Payment of Benefits	Benefits of this plan are available only to members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan. At our option only and in accordance with the law, we may pay the benefits of this plan to: • The subscriber. • A provider. • Another health insurance carrier. • The member. • Another party legally entitled under federal or state medical child support laws. • Jointly to any of the above. Payment to any of the above satisfies our obligation as to payment of benefits.
Venue	All suits or legal proceedings brought against us by you or anyone claiming any right under this plan must be filed: • Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable. • In the state of Washington or the state where you reside or are employed. All suits or legal or arbitration proceedings brought by us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in King County, the state of Washington.
Women's Health and Cancer Rights Act of 1998	Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Please see ***Covered Services***.
Workers' Compensation Insurance	This contract is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera Blue Cross HMO 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.

Premera Blue Cross HMO covers only limited healthcare services received outside of Premera Blue Cross HMO's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care services obtained outside the geographic area Premera Blue Cross HMO serves. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the member's primary care physician or us.

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

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

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

BlueCard Program

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

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

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

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

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

Taxes, Surcharges and Fees

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

Non-Contracted Providers

It could happen that you receive covered services from providers outside our service area that do not have a contract with the Host Blue. In most cases we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. Please see the definition of "allowed amount" in ***Important Plan Information*** of this booklet for details on allowed amounts.

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

Blue Cross Blue Shield Global® Core

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core. Blue Cross Blue Shield Global® Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global® Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***Sending Us A Claim*** for more information. However, if you need hospital inpatient care, the service Center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

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

More Questions

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

ADDITIONAL INFORMATION ABOUT YOUR COVERAGE

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

You may also ask for the following information:

- Your right to seek and pay for care outside of this plan.
- The plan's drug list, also called a "formulary".

- How we pay providers.
- How providers' payment methods help promote good patient care.
- A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations.
- How to file a complaint and a copy of our process for resolving complaints.
- How to access specialists.
- Obtaining a prior authorization when needed.
- Accreditation by national managed care organizations.
- Use of the health employer data information set (HEDIS) to track performance.

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

Definitions

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

Adverse Benefit Determination	An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes • A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage • A limitation on otherwise covered benefits • A clinical review decision • A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective • A decision related to compliance with protections against balance billing as defined by federal and state law
Affordable Care Act	The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
Ambulatory Surgical Facility	A healthcare facility where people get surgery without staying overnight. An ambulatory surgical facility must be licensed or certified by the state it is in. It also must meet all of these criteria: • It has an organized staff of providers • It is a permanent facility that is equipped and run mainly for doing surgical procedures • It does not provide Inpatient services or rooms
Applied Behavioral Analysis (ABA)	The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially

	significant improvement in human behavior or to prevent the loss of an attained skill or function.
Autism Spectrum Disorders	Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, as amended or reissued from time to time.
Benefit	What this plan provides for a covered service. The benefits you get are subject to this plan's cost-shares.
Benefit Booklet	Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.
Calendar Year (Year)	A 12-consecutive month period that starts each January 1 and ends on December 31.
Claim	A request for payment from us according to the terms of this plan.
Clinical Trials	An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by one of the following: • An institutional review board that complies with federal standards for protecting human research subjects; and • The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers • United States Food and Drug Administration (FDA) • The United States Department of Defense • The United States Department of Veterans' Affairs • A nongovernmental research entity abiding by current National Institutes of Health guidelines
Community Mental Health Agency	An agency that's licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.
Comprehensive Oral Evaluation	Comprehensive oral evaluations include complete dental/medical history and general health assessment, complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; the evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screenings.
Congenital Anomaly 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.

Cosmetic Services	Services that are performed to reshape normal structures of the body in order to improve your appearance and self-esteem and not primarily to restore an impaired function of the body.
Cost-Share	The part of healthcare costs that you have to pay. Examples are deductibles, coinsurance, copayments, and similar charges. It does not include subscription charges, amounts over the allowed amount billed by health care providers who are out of the network, or the cost of services not covered by this plan. See ***Covered Services*** section to find out what your cost-shares are.
Covered Service	A service, supply or drug that is eligible for benefits under the terms of this Plan.
Custodial Care	Any part of a service, procedure, or supply that is mainly to: Maintain your health over time, and not to treat specific illness or injury. Help you with activities of daily living. Examples are help in walking, bathing, dressing, eating, and preparing special food. This also includes supervising the self-administration of medication when it does not need the constant attention of trained medical providers.
Dental Emergency	A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.
Dentally Necessary and Dental Necessity	Those covered services which are determined to meet all of the following requirements: • Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan. • Appropriate and consistent with authoritative dental or scientific literature. • Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider.
Dependent	The subscriber's spouse or domestic partner and any children who are on this plan.
Detoxification	Detoxification is active medical management of substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance ingested, repeated vital sign monitoring, and use of medication to manage intoxication or withdrawal. Observation without active medical management, or any service that is claimed to be detoxification but does not include active medical management, is not detoxification.
Doctor (Also called	A state-licensed:

"Physician")	• 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 their state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a doctor as defined above: • Chiropractor (D.C.). • Dentist (D.D.S. or D.M.D.). • Optometrist (O.D.). • Podiatrist (D.P.M.). • Psychologist. • Nurse (R.N. and A.R.N.P.) licensed in Washington State
Effective Date	The date your coverage under this plan begins.
Emergency Medical Condition	A medical, mental health, or substance use disorder condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would: • Place the health of a person, or an unborn child in the case of a pregnant member, in serious jeopardy. • Result in serious impairment to bodily functions. • With respect to a pregnant member who is having contractions, for which there is inadequate time to affect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the member or the unborn child. Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.
Emergency Services	• Services and supplies including ancillary services given in an emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health. • Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery. • Ambulance transport as needed in support of the services above.
Endorsement	A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.

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/Investigative Services	A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria: • A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided. • It is subject to oversight by an Institutional Review Board. • There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition. • It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. • Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies. Reliable evidence means only published reports and articles in authoritative medical and scientific literature.
Facility (Medical Facility)	A hospital, skilled nursing facility, approved treatment facility for chemical dependency, state-approved institution for treatment of mental or psychiatric conditions, or hospice. Not all health care facilities are covered under this contract.
Health Care Benefit Managers	Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.
Home Health Agency	An organization that provides covered home health care services to a member.
Home Medical Equipment (HME)	Equipment ordered by a provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as “Durable Medical Equipment” or “DME”.

Hospice	A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.
Hospital	A healthcare facility that meets all of these criteria: • It operates legally as a hospital. • It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients. • It has a staff of providers that provides or supervises the care. • It has 24-hour nursing services provided by or supervised by registered nurses. A facility is not considered a hospital if it operates mainly for any of the purposes below: • As a rest home, nursing home, or convalescent home. • As a residential treatment center or health resort. • To provide hospice care for terminally ill patients. • To care for the elderly. • To treat chemical dependency or tuberculosis.
Illness	A sickness, disease, or medical condition.
Injury	Physical harm caused by a sudden event at a specific time and place. It is independent of illness, except for infection of a cut or wound.
In-Network Pharmacy (In-Network Retail/In-Network Mail Order Pharmacy)	A licensed pharmacy which contracts with us or our Pharmacy Benefit Manager to provide prescription drug benefits.
Inpatient	Confined in a medical facility or as an overnight bed patient.
Limited Oral Evaluation – Problem Focused	A limited oral evaluation – problem focused is an evaluation limited to a specific oral health problem or complaint and may include evaluation of a specific dental problem or oral health complaint, dental emergency and referral for other treatment.
Long-term Care Facility	A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.023, or assisted living facility licensed under chapter 18.20 RCW.
Medical Equipment	Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.
Medical Facility (also called "Facility")	A hospital, skilled nursing facility, state-approved chemical dependency program or hospice.
Medically Necessary and	Services a physician, exercising prudent clinical judgment, would use with

Medical Necessity	a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must: • Agree with generally accepted standards of medical practice • Be clinically appropriate in type, frequency, extent, site and duration., They must also be considered effective for the patient's illness, injury or disease • Not be mostly for the convenience of the patient, physician, or other healthcare provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
Member (also called "You" or "Your")	Any person covered under this plan.
Orthodontia	The branch of dentistry which specializes in tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).
Orthotic	A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.
Outpatient	A person who gets healthcare services without an overnight stay in a healthcare facility. This word also describes the services you get while you are an outpatient.
Outpatient Surgical Center	A facility that's licensed or certified as required by the state it operates in and that meets all of the following: • It has an organized staff of physicians • It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures • It doesn't provide inpatient services or accommodations Pharmacy Benefit Manager • An entity that contracts with us to administer the ***Prescription Drugs*** benefit under this plan.
Plan	The benefits, terms, and limitations stated in the contract between us and the Group. This booklet is a part of the contract.
Prescription Drugs	Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription." Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for

	treatment of such condition by: One of the following standard reference compendia: • The American Hospital Formulary Service-Drug Information • The American Medical Association Drug Evaluation • The United States Pharmacopoeia-Drug Information • Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts) "Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling. Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.
Primary Care Provider (PCP)	A provider who both provides primary care and coordinates care to other medical services
Prior Authorization	Prior authorization is a process that requires you or a provider to follow before a service is given, to determine if a service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care or effectiveness. You must ask for prior authorization before the service is delivered. See ***Prior Authorization*** for details.
Provider	A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care-related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of their employment. Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law. Covered categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met: The providers are: • Acupuncturists (L.Ac.) (In Washington also called East Asian Medicine Practitioners (E.A.M.P.)). • Audiologists.

	• Chiropractors (D.C.). • Counselors. • Dental Hygienists (under the supervision of a D.D.S. or D.M.D.). • Dentists (D.D.S. or D.M.D.). • Denturists. • Dietitians and Nutritionists (D. or C.D., or C.N.). • Gynecologists. • 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. • Obstetricians. • Occupational Therapists (O.T.A.). • Ocularists. • Opticians (Dispensing). • Optometrists (O.D.). • Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.). • Osteopathic Physicians (D.O.). • Pharmacists (R.Ph.). • Physical Therapists (L.P.T.). • Physician Assistants (P.A.) (under the supervision of an M.D.). • Physicians (M.D.). • Podiatric Physicians (D.P.M.). • Psychologists (Ph.D.). • Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.). • Respiratory Care Practitioners. • Social Workers. • Speech-Language Pathologists. The following healthcare facilities and other providers will also be considered providers for the purposes of this plan when they meet requirements above. • Ambulance Companies. • Ambulatory Diagnostic, Treatment and Surgical Facilities. • Audiologists (CCC-A or CCC-MSPA). • Birthing Centers. • Blood Banks. • Board Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed in states that have specific licensure for behavior analysts. • Community Mental Health Centers. • Drug and Alcohol Treatment Facilities. • Medical Equipment Suppliers.

	• Hospitals. • Kidney Disease Treatment Centers (Medicare-certified). • Psychiatric Hospitals. • Speech Therapists (Certified by the American Speech, Language and Hearing Association). In states other than Washington, "provider" means healthcare practitioners and facilities that are licensed or certified consistent with the laws and regulations of the state in which they operate. This plan makes use of provider networks as explained in ***How Providers Affect Your Costs***.
Psychiatric Condition	A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for chemical dependency.
Reconstructive Surgery	Reconstructive Surgery is surgery: That restores features damaged as a result of injury or illness To correct a congenital deformity or anomaly.
Rehabilitative Services	Rehabilitative services or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition. Rehabilitative services include physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope of their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.
Service Area	Pierce, Spokane, and Thurston County in Washington State
Services	Services are procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.
Skilled Care	Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.
Skilled Nursing Facility	A medical facility licensed by the state to provide nursing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.
Specialist	A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse	Spouse means: • An individual who is legally married to the subscriber • An individual who is a state registered domestic partner of the subscriber or who meets the requirements for domestic partner coverage under this plan.
Subscriber	An enrolled employee of the Participating Employer. Coverage under this plan is established in the subscriber's name.
Subscription Charge	The monthly rates we establish as consideration for the benefits offered under this contract.
Substance Use Disorder (Also called Chemical Dependency)	Dependence on or addiction to drugs or alcohol. It can be a physiological (physical) dependency or a psychological (mental) dependency or both. People with substance use disorders usually use drugs or alcohol in a frequent or intense pattern that leads to: • Losing control over the amount and circumstances of use. • Developing a tolerance of the substance or having withdrawal symptoms if they reduce or stop the use. • Making their health worse or putting it in serious danger. • Not being able to function well socially or on the job. • Physical consequences of use such as drug psychoses and drug dependence syndromes. State and federal law require that the copays and coinsurance for medically necessary outpatient and inpatient services provide to treat substance use disorder will be no more than the copays and coinsurance for medical and surgical services. Prescription drugs to treat substance use disorder are covered under the same terms and conditions as other prescription drugs covered under this plan.
Urgent Care	Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away, but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.
Virtual Care	Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused. Originating site: Hospital, Rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center.
Visit	A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.
Visual Oral Screenings or Assessments	Performed by a licensed dentist or dental hygienist under the supervision of a licensed dentist to determine the need for sealants, fluoride treatment, and/or when triage services are provided in settings other than dental offices or dental clinics.
We, Us and Our	Premera HMO