School Employees Benefits Board (SEBB) Program

High PPO Plan

4018486

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INTRODUCTION

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

If any provision of this Plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.

Group Name:	Washington State Healthcare Authority For The School Employees Benefits Board Program
Effective Date:	January 1, 2025
Group Number:	4018486
Plan:	High PPO Plan
Certificate Form Number:	40184860125A

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Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
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និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ
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Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਦਾਸਤੇ ਕਾਲ ਕਰੋ।
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Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
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Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
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برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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HOW TO USE THIS BOOKLET

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

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

FOR MORE INFORMATION

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

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

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

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

You can use our website to:

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

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SUMMARY OF YOUR COSTS

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

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

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

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

	In-Network Providers
Non-specialist professional visit copay	$25
Specialist professional visit copay	$50

- **Deductible**. The total allowed amount you pay in each year before this plan starts to make payments for your covered healthcare costs. You pay down each deductible separately with each claim that applies to it.

	In-Network Providers	**Out-of-Network Providers**
Individual deductible	$750	$1,500
Family deductible (not shown in the summary table)	$1,875	$3,750

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

	In-Network Providers	**Out-of-Network Providers**
Coinsurance	25%	50%

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

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$3,500	None
Family out-of-pocket maximum	$7,000	None

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

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

SUMMARY TABLE

The summary table below shows plan limits and what you pay (your cost shares) for covered services. Facility in the table below means hospitals or other medical institutions. **Professional** means doctors, nurses, and other people who give you your care. When you see the term **“No charge”** in the table below, this means that you do not have to pay any deductible, copay or coinsurance for covered services and the provider cannot bill

you any amount. **No cost shares** means that although you do not pay any deductible, copay or coinsurance for covered services, the provider can bill you for amounts over the allowed amount. You will not be balanced billed for certain services provided by a non-contracted provider. A non-participating provider can bill you for amounts over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law.

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture calendar year visit limit: 24 visits Substance use disorder-related: no limit	$25 copay per visit, deductible waived	Deductible, then 50% coinsurance
Allergy Testing And Treatment	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Ambulance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Blood Products and Services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Cellular Immunotherapy And Gene Therapy You may have additional costs for other services such as x-rays, labs, prescription drugs, and hospital facility charges. See those covered services for details.	Covered as any other in-network service	Covered as any other out-of-network service
Chemotherapy and Radiation Therapy Professional and facility services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Clinical Trials Covers routine patient care during the trial You may have additional costs for other services such as x-rays, lab, prescription drugs, and hospital facility charges. See those covered services for details.	Covered as any other service	Covered as any other service
Dental Injury and Facility Anesthesia		
• **Dental Anesthesia** (See ***Dental Injury and Facility*** benefit for details.)		
• Inpatient facility care, and all other professional services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Outpatient surgery center	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Anesthesiologist	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• **Dental Injury**		
• Exams to determine treatment needed	$50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Treatment	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Diagnostic X-Ray, Lab And Imaging for medical conditions or symptoms		
Tests, lab, imaging and scans	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Diagnostic and supplemental breast exams	No charge	Deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Dialysis For permanent kidney failure. See the ***Dialysis*** benefit for details. • During Medicare's waiting period • After Medicare's waiting period	Deductible, then 25% coinsurance No charge	Deductible, then 50% coinsurance No cost shares
Emergency Room • Facility charges You may have additional costs for other services. Examples are X-rays or lab tests. See those covered services for details. The copay is waived if you are admitted as an inpatient through the emergency room. The copay is waived if you are transferred and admitted to a different hospital directly from the emergency room. • Professional services	$150 copay per visit, deductible, then 25% coinsurance Deductible, then 25% coinsurance	$150 copay per visit, deductible, then 25% coinsurance Deductible, then 25% coinsurance
Foot Care such as trimming nails or corns, when medically necessary due to a medical condition • In an office or clinic • All other settings	$25 or $50 copay per visit, deductible waived Deductible, then 25% coinsurance	Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Gender Affirming Care • Office and clinic visits • Other professional services • Inpatient facility care	$25 or $50 copay per visit, deductible waived Deductible, then 20% coinsurance Deductible, then 20% coinsurance	Deductible, then 50% coinsurance Deductible, then 50% coinsurance Deductible, then 50% coinsurance
Hearing Care For hearing loss, often due to age or noise exposure. • **Hearing Exams** Limit each calendar year:1 exam/test • **Hearing Hardware** Limit of $3,000 per ear every 36 months	No charge No charge	Deductible, then 50% coinsurance No cost shares
Home Health Care calendar year visit limit: None • Home visits • Prescription drugs billed by the home health agency	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies • Sales tax for covered items • Foot orthotics and therapeutic shoes; calendar year limit: $300 except diabetes related • Medical vision hardware	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Hospice Care Lifetime limit for terminal illness: 6 months Lifetime limit for non-terminal illness: none Inpatient stay limit: 30 days Home visits: Unlimited Respite care: 240 hours lifetime max		
• Inpatient facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Home and respite care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Prescription drugs billed by the hospice	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Hospital • **Inpatient Care**		
• Professional	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Facility	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• **Outpatient Care**		
• Professional	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Facility	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Infusion Therapy	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Massage therapy calendar year limit: 24 visits	$25 copay per visit, deductible waived	Deductible, then 50% coinsurance
Mastectomy and Breast Reconstruction		
• Office and clinic visits	$25 or $50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Surgery and other professional services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	YOUR SHARE OF THE ALLOWED AMOUNT OUT-OF-NETWORK PROVIDERS
Maternity Care Care during pregnancy, childbirth and after the baby is born. See the ***Preventive Care*** benefit for routine exams and tests during pregnancy.		
• Professional care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient hospital, birthing centers and short-stay hospitals	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Abortion	No charge	Deductible, then 50% coinsurance
Medical Foods includes phenylketonuria (PKU)	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Medical Transportation Travel and lodging are covered up to the IRS limitations Prior approval required.		
• **For Transplants:** $7,500 overall limit, per transplants	Deductible, then 0% coinsurance	In-network deductible, then 0% coinsurance
• **For Cellular Immunotherapy and Gene Therapy**: $7,500 per episode of care	No charge	No cost-shares
Special criteria are required for travel benefits to be provided. See the benefit coverage for details.		
Medical Transportation – State Restricted Care Benefits are limited to members residing in states where laws restrict access to care. Travel and lodging are covered up to the IRS limitations. Prior approval required.		
• To/from provider for abortion services	No charge	No charge
• To/from provider for medically necessary gender affirming care services	No charge	No charge
• Calendar year limit: $4,000		
Special criteria are required for travel benefits to be provided. See the benefit for coverage details.		

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	 OUT-OF-NETWORK PROVIDERS
Mental Health Care		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient and residential facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Outpatient facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Neurodevelopmental Therapy (Habilitation) See the ***Mental Health Care benefit*** for therapies for mental conditions such as autism.		
• Outpatient care calendar year visit limit: 45 visits		
• Office and clinic visits	$50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Other outpatient services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient care calendar year day limit: 45 days	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Newborn Care		
• Inpatient care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Office and clinic visits	$25 or $50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Other outpatient services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Orthognathic Surgery (Jaw Augmentation or Reduction) lifetime limit: None		
• Office and clinic visits	$25 or $50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Surgery and other professional care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Outpatient surgery facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient hospital care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance

	YOUR SHARE OF THE ALLOWED AMOUNT	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Prescription Drug Deductible Separate from medical deductible	**In-Network Pharmacy**	**Out-Of-Network Pharmacy**
• Generic drugs	Waived	Waived
• Individual deductible for brand-name and specialty drugs	$125	$125 (separate from in-network drug deductible)
• Family deductible for brand-name and specialty drugs	$312	$312 (separate from in-network drug deductible)
Covered Drugs*	**In-Network Retail Pharmacy**	**Out-Of-Network Retail Pharmacy**
• Preferred Generic drugs	$9 copay	$9 copay plus 40% coinsurance
• Preferred brand name drugs	$40 copay	$40 copay plus 40% coinsurance
• Non-preferred generic and brand name drugs	50% coinsurance	90% coinsurance
	In-Network Mail-Order Pharmacy	**Out-Of-Network Mail-Order Pharmacy**
• Preferred Generic drugs	$18 copay	Not covered
• Preferred brand name drugs	$80 copay	Not covered
• Non-preferred generic and brand name drugs	50% coinsurance	Not covered
**Your cost shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug. The deductible does not apply. Cost shares for covered prescription insulin drugs apply toward the deductible.*		
Specialty Drugs (per prescription or refill). You must use a specialty pharmacy for these drugs to be covered.	**In-Network Retail Pharmacy**	**Out-Of-Network Retail Pharmacy**
• Preferred specialty drugs	$75 copay	Not covered
• Non-preferred specialty drugs	50% coinsurance	Not covered
Exceptions	**In-Network Retail or In-Network Mail Order Pharmacy**	**Out-Of-Network Retail Pharmacy**
• Needles and syringes purchased with diabetic drugs	No charge	No cost shares
• Certain prescription drugs and generic over-the-counter drugs to break a nicotine habit	No charge	Same as out-of-network retail
• Drugs on the Affordable Care Act's preventive drug list	No charge	Same as out-of-network retail
• Oral chemotherapy drugs	No charge	No cost shares

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	 OUT-OF-NETWORK PROVIDERS
• Contraceptive drugs, devices and supplies (prescription and over-the-counter). Includes emergency contraceptive.	No charge	Same as out-of-network retail
Preventive Care (Limits on how often services are covered and who services are recommended for may apply.)		
• Preventive exams, including vision and oral health screening for members under 19, diabetes and depression screening	No charge	Not covered
• Fall prevention for members 65 and older	No charge	Not covered
• Immunizations in the provider's office	No charge	Not covered
• Flu shots and other seasonal immunizations at a pharmacy or mass immunizer location	No charge	No cost shares
• Travel immunizations at a travel clinic or county health department	No charge	No cost shares
• Health education and training (outpatient)	No charge	Not covered
• Nicotine habit-breaking programs	No charge	Not covered
• Nutritional counseling and therapy	No charge	Deductible, then 50% coinsurance
• Pregnant member’s care (includes breast-feeding support and post-partum depression screening)	No charge	Deductible, then 50% coinsurance
• Screening tests (includes prostate and cervical cancer screening)	No charge	Deductible, then 50% coinsurance
• Screening mammograms	No charge	Deductible, then 50% coinsurance
• Colorectal cancer screening	No charge	Deductible, then 50% coinsurance
• Contraceptive and sterilization.	No charge	Deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	YOUR SHARE OF THE ALLOWED AMOUNT OUT-OF-NETWORK PROVIDERS
Professional Visits and Services You may have extra costs for other services like lab tests and facility charges. Also see ***Allergy Testing And Treatment*** and ***Therapeutic Injections***.		
• Office and clinic visits	$25 or $50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Telemedicine with Traditional Providers (General Medical)	$25 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Electronic visits (e-visits)	$25 or $50 copay per visit, deductible waived	Not covered
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Psychological and Neuropsychological Testing	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Rehabilitation Therapy • Outpatient Care calendar year visit limit: 45 visits No limit for cardiac or pulmonary rehabilitation programs, or similar programs for cancer or other chronic conditions.		
• Office and clinic visits	$50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Other outpatient services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient Care calendar year day limit: 45 days	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Skilled Nursing Facility Care calendar year day limit: None	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Spinal and Other Manipulations calendar year visit limit: 24 visits	$25 copay per visit, deductible waived	Deductible, then 50% coinsurance
Substance Use Disorder		
• Office and clinic visits	$25 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient care and residential facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Outpatient facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	YOUR SHARE OF THE ALLOWED AMOUNT OUT-OF-NETWORK PROVIDERS
Surgery (includes professional services, anesthesia and blood transfusions) See the ***Hospital*** and ***Surgical Center Care - Outpatient*** benefits for facility charges.	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Vasectomy	No charge	Deductible, then 50% coinsurance
Surgical Center Care – Outpatient	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Temporomandibular Joint Disorders (TMJ) Care		
• Office and clinic visits	$25 or $50 copay per visit, deductible waived	Deductible, then 50% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Inpatient facility care	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Therapeutic Injections	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Transplants (Includes donor search and donation costs)		
• Inpatient facility care	Deductible, then 25% coinsurance	Not covered*
• Office and clinic visits	$25 or $50 copay per visit, deductible waived	Not covered*
• Surgery and other professional services	Deductible, then 25% coinsurance	Not covered*
All approved transplant centers covered at the in-network level* See ***Medical Transportation* for travel and lodging benefits.		
Urgent Care Services at an urgent care center. See ***Diagnostic X-Ray, Lab And Imaging*** for tests received while at the center. Your deductible and coinsurance apply to facility charges.		
• Freestanding urgent care centers	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
• Urgent care centers attached to or part of a hospital	$150 copay per visit, then deductible, then 25% coinsurance	$150 copay per visit, then deductible, then 25% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT IN-NETWORK PROVIDERS	 OUT-OF-NETWORK PROVIDERS
Virtual Care Interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment		
• Virtual general medical/dermatology visits	$5 copay, deductible waived	Not applicable
• Virtual behavioral/mental health	$25 copay, deductible waived	Not applicable
• Virtual substance use disorder visit	$25 copay, deductible waived	Not applicable
Weight Management • Non-surgical weight management • Surgical weight loss treatment (Bariatric Surgery) See the ***Weight Management*** benefit for additional benefit information.	Covered as any other in-network service Deductible, then 25% coinsurance	Covered as any other out-of-network service Not covered

HOW PROVIDERS AFFECT YOUR COSTS

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

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

This plan does not require use or selection of a primary care provider or require referrals for specialty care. Members may self-refer to providers, including obstetricians, gynecologists and pediatricians, to receive care, and may do so without prior authorization.

In-Network Providers

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

In-Network providers are:

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

In-Network pharmacies are available nationwide.

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

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

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

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

Contracted Health Care Benefit Managers

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

Continuity of Care

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

COC applies in these situations:

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

How you qualify for Continuity of Care If a primary care provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination. Additionally, you may qualify for continuing care from non-primary care providers if you are in an "active relationship" or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

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

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

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

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

- The 90th day after we notified you that your provider's contract ended
- The day after you complete the active course of treatment entitling you to continuity of care

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

Continuity of care does not apply if your provider:

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

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

Non-Participating Providers

Non-participating providers are either (1) providers that are not in one of the networks (Out-Of-Network) shown above under, "In-Network Providers," or (2) providers that do not have a contract with us (Non-Contracted). Except as stated in ***Benefits For Out-Of-Network Or Non-Contracted Providers***, or for a few specific benefits, services from these providers are not covered.

- **Out-of-Network** Some providers in Washington have a contract with Premera Blue Cross, but are not in the Heritage Prime network. In cases where this plan covers services from these providers, they will not bill you for

any amount above the allowed amount for a covered service. The same is true for a provider that is in a different network of the local Host Blue plan.

- **Non-Contracted Providers** There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers are called "non-contracted" providers in this booklet. You may also be required to submit the claim yourself. See ***How Do I File A Claim?*** for details.

Balance Billing Protection

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

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

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

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

Ground Ambulance Services from a non-participating ground ambulance service organization for covered ground ambulance services.

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

For more information, refer to www.insurance.wa.gov/sites/default/files/documents/consumer-notice-suprise-billing-2023.pdf.

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

Note: The surprise billing protection does not apply to any other service from a non-contracted provider. If the service is not listed above, you must pay any amounts over the plan’s allowed amount for the service if you are billed by the provider. Amounts you pay over the allowed amount don’t count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Benefits For Out-Of-Network Or Non-Contracted Providers

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

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

  The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider or facility furnishing the services has a contract with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.
- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Facility and hospital-based provider services received from a hospital that has a provider contract with Premera Blue Cross.
- Covered services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

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

IMPORTANT PLAN INFORMATION

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

The allowed amount is also explained.

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

COPAYMENTS (COPAYS)

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

SPLIT COPAY FOR OFFICE VISITS

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

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

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

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

CALENDAR YEAR DEDUCTIBLE

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

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

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

Note: Each calendar year deductible accrues toward its applicable out-of-pocket maximum, if any.

Individual Deductible

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

Family Deductible

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

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

What Doesn't Apply To The Calendar Year Deductible?

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

- Amounts that exceed the allowed amount
- Charges for excluded services
- The penalty for not asking for prior authorization when the plan requires it. See ***Prior Authorization*** in ***Care Management*** of this booklet.
- The difference in cost between a brand name drug and an equivalent generic drug when the plan requires the generic drug to be dispensed in place of the brand name drug.
- Copays
- The coinsurance for in-network pharmacies stated in the ***Summary Of Your Costs***

COINSURANCE

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

OUT-OF-POCKET MAXIMUM

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

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

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

- Your coinsurance
- The calendar year deductibles

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

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

- Charges above the allowed amount
- Charges not covered by the plan
- Copays for exams covered under the Hearing Exams benefit
- The penalty for not requesting prior authorization when needed. See ***Prior Authorization*** in ***Care Management*** of this booklet.

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

Note: In order to satisfy the in-network out-of-pocket amount, no enrolled family member has to pay more than the individual out-of-pocket maximum.

ALLOWED AMOUNT

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply. The allowed amount is described below. There are different rules for certain services as described below. These rules are shown below the general rules.

General Rules

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

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

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

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

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

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

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

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

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

  Non-Emergency Services Protected From Balance Billing

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

Emergency Services

The allowed amount for non-participating providers will be calculated consistent with the requirements of federal or Washington state law. You do not have to pay amounts over the allowed amount for emergency services delivered by non-participating or non-contracted providers or facilities.

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

Ground or Air Ambulance

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

COVERED SERVICES

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be medically necessary (see ***Definitions*** in this booklet) and must be furnished in a medically necessary setting.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan.
- It must be furnished by a "provider" (see ***Definitions*** in this booklet) who's performing services within the scope of their license or certification.
- It must meet the standards set in our medical and payment policies. The plan uses policies to administer the terms of the plan. Medical policies define medical necessity criteria for specific procedures, drugs, biologic agents, devices, level of care or services. They also identify medical services that are not covered because they are experimental and investigational. Medical policies may be developed by Premera or licensed from national organizations that create evidence-based utilization standards. =Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at www.premera.com or by calling customer service.

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

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

Acupuncture

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

This benefit covers acupuncture to:

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

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

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

Allergy Testing and Treatment

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

This benefit covers:

- Testing
- Allergy shots
- Serums

Ambulance

This benefit covers:

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

These services are only covered when:

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

Air or sea emergency medical transportation is covered when:

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

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

Ground ambulance services means:

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

This benefit does not cover:

- Services from an unlicensed ambulance

Blood Products And Services

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

Cellular Immunotherapy And Gene Therapy

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

These therapies are fairly new, and their use is evolving. They must meet three criteria in order to be covered:

- Prescribed by a provider
- Meet Premera’s medical policy (See premera.com/sebb or call customer service), and
- Approved by Premera before they can happen (See ***Prior Authorization***)

This benefit covers:

Medically necessary cellular immunotherapy and gene therapy, like Chimeric Antigen Receptor T-Cell (CAR-T).

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.

Chemotherapy And Radiation Therapy

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

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

This benefit covers:

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

For chemotherapy drugs you get from a pharmacy, see ***Prescription Drug***. Some services need to be pre-approved before you get them. See ***Prior Authorization*** for details.

Clinical Trials

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

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

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

This benefit doesn't cover:

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

Dental Injury and Facility Anesthesia This benefit will only be provided for the dental services listed below.

Dental Anesthesia

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

This benefit covers:

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

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

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

Dental Injury

Treatment of dental injuries to teeth, gum and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment
- Oral surgery

This benefit is covered on sound and natural teeth that:

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

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

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

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

Diagnostic X-Ray, Lab And Imaging

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

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

Covered services include:

- Basic diagnostic images and scans
- Major diagnostic images and scans:
- Computed Tomography (CT) scan
- High technology ultrasound
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan

Diagnostic breast examination for the purpose of this ***Diagnostic X-Ray, Lab, And Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality:

- seen or suspected from a screening examination for breast cancer; or
- detected by another means of examination

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

- used to screen for breast cancer when there is no abnormality seen or suspected; and

- based on personal or family medical history, or additional factors that may increase the member's risk or breast cancer

For additional details see the following benefits:

- Emergency Room
- Hospital
- Maternity Care
- Preventive Care
- Genetic testing may be covered in some cases. Call customer service before seeking testing since it may require prior authorization. When prescribed by an in-network provider, Prior Authorization is not required for members with state 3 or 4 cancer, or for members with recurrent, relapsed, refractory, or metastatic cancer.

Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.
This benefit does not cover non-diagnostic testing or screening required for employment, schooling, or public health reasons that is not for the purpose of treatment.

Dialysis

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

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

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

When covered dialysis services are provided by an out-of-network provider in a county in Washington state where no in-network providers are available, the in-network cost shares will apply. If the dialysis services are provided by a non-contracted provider and you do not enroll in Medicare, then you will owe the difference between the non-contracted provider's billed charges and the payment we will make for the covered services.

Emergency Room

This benefit covers:

- Emergency room and provider services
- Equipment, supplies and drugs used in the emergency room
- Services and exams used for stabilizing an emergency medical condition, including mental health, or substance use disorder.
- Diagnostic tests performed with other emergency services
- Medically necessary detoxification

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

Foot Care

This benefit covers:

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

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

Gender Affirming Care

Benefits for medically necessary gender affirming medical care or surgery are subject to the same cost shares that you would pay for inpatient or outpatient treatment for other covered medical conditions. To find the amounts you are responsible for, see the ***Summary of Your Costs*** earlier in this booklet. If you can't find an in-network provider, or need information about what services are covered under your plan, call customer service.

Gender transition or affirmation is the process of changing the gender characteristics a person was born with to the gender characteristics with which a person identifies. Benefits are provided for gender affirming medical care or surgery which meet the requirements of Premera's medical policy, including facility and anesthesia charges related to surgery. For more information, visit www.premera.com/visitor/care-essentials/lgbt-health. Additionally, our medical policies are available from customer service, or at www.premera.com/sebb.

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

For members residing in states where laws prohibit access to medically necessary gender affirming care services, travel to a provider in another state may be covered. See ***Medical Transportation – State-Restricted Care*** for details. For covered surgery benefits not part of gender affirming care, see ***Surgery***. Some surgeries need prior authorization before you get them. See ***Prior Authorization*** for details.

Hearing Care

Hearing Exams

Hearing exam services include:

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

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

Hearing Hardware

To receive your hearing hardware benefit:

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

Benefits are provided for the following:

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

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

- an otolaryngologist for an initial evaluation of hearing loss; or

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

This benefit doesn't cover:

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

Home Health Care

General Home Health Care

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

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

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

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

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

Skilled Hourly Nursing

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

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

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

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

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

- Over-the-counter drugs, solutions and nutritional supplements

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

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

This benefit covers:

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

Covered items include:

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

Medical Supplies such as:

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

Medical Vision Hardware to correct vision due to the following medical eye conditions:

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

External Prosthetics and Orthotic Devices used to:

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

Orthopedic Shoes and Shoe Inserts

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

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

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs. These services are covered under ***Prescription Drug***.
- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Over bed tables, elevators, vision aids, and telephone alert systems
- Over-the-counter orthotic braces and/or cranial banding
- Non-wearable external defibrillators, trusses and ultrasonic nebulizers
- Blood pressure cuffs/monitors (even if prescribed by a physician)
- Enuresis alarm
- Compression stockings which do not require a prescription
- Physical changes to your house or personal vehicle
- Orthopedic shoes used for sport, recreation or similar activity
- Penile prostheses
- Routine eye care
- Prosthetics, intraocular lenses, equipment or devices which require surgery. These items are covered under the ***Surgery*** benefit.

Hospice Care

To be covered, hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (MD or DO).

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

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

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

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

Covered services are:

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

This benefit doesn't cover:

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

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

Hospital

This benefit covers:

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

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

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

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

This benefit does not cover:

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

Infusion Therapy

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

Infusion examples include:

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

This benefit covers:

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

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

Massage Therapy

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

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

Mastectomy and Breast Reconstruction

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

This benefit covers:

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

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

Maternity Care

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

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

Facility Care

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

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

Professional Care

This benefit covers

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

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

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

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

For members residing in states where laws prohibit access to abortion services, travel to a provider in another state may be covered. See ***Medical Transportation – State-Restricted Care*** for details.

Medical Foods

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

This benefit covers:

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

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

This benefit does not cover:

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

Medical Transportation

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

- Travel related to the covered transplants named in the ***Transplants*** benefit. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members when the member is not in the hospital and for their companion. The member getting the transplant must live more than 50 miles from the transplant facility unless treatment protocols require the member to remain closer to the transplant center.
- Travel for cellular immunotherapy and gene therapy. Benefits are provided for travel for the member and one companion to a designated provider outside the service area, when a designated provider is not available within the service area. See ***Cellular Immunotherapy and Gene Therapy***.

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

Benefits are provided for:

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

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

Companion Travel

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

Reimbursement of Travel Claims

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

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

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

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

This benefit does not cover:

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

Medical Transportation – State-Restricted Care

This plan provides benefits for travel and lodging for abortion and medically necessary gender affirming care services when the member resides in a state where laws restrict access to these covered services. Prior approval is required. Please call customer service to verify if you are eligible for this benefit and to obtain prior approval.

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

Benefits are provided for:

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

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

Companion Travel

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

Reimbursement of Travel Claims

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

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

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

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

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

This benefit does not cover:

- Charges and fees for booking changes
- Cancellation fees
- First class airline fees
- International travel
- Lodging at any establishment that is not commercial
- Meals
- Personal care items
- Pet care, other than for service animals
- Phone service and long-distance calls
- Reimbursement for mileage rewards or frequent flier coupons
- Reimbursement for travel before contacting us and receiving prior approval
- Travel for medical procedures not listed above
- Travel in a mobile home, RV, or travel trailer
- Travel insurance
- Reimbursement for companion travel and lodging, except for medical necessity or safety of the patient

Mental Health Care

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

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

Covered mental health services are:

- Inpatient care
- Outpatient therapeutic visits. "Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Current Procedural Terminology** manual, published by the American Medical Association. Outpatient

therapeutic visits can include real-time visits via telephone, online chat or text, or other electronic methods with your doctor or other provider who also maintains a physical location.

- Treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
- Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders.
- Applied behavioral analysis (ABA) therapy for members with one of the following:
  - Autistic disorder
  - Autism spectrum disorder
  - Asperger's disorder
  - Childhood disintegrative disorder
  - Pervasive developmental disorder
  - Rett's disorder

  Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all ABA services for a member may be managed by a BCBA or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques. ABA therapy must be provided by:
  - A licensed physician (MD or DO) who is a psychiatrist, developmental pediatrician or pediatric neurologist
  - A licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
  - A licensed occupational or speech therapist
  - A licensed psychologist (PhD)
  - A licensed community mental health agency or behavioral health agency that is also state-certified to provide ABA therapy.
  - A Board-Certified Behavior Analyst (BCBA). This means a provider who is state-licensed if the State licenses behavior analysts (Washington does). If the state does not require a license, the provider must be certified by the Behavior Analyst Certification Board. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.
  - A therapy assistant/behavioral technician/paraprofessional, when their services are supervised and billed by a licensed provider or a BCBA.

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

- Hospital
- State-Licensed Community Mental Health Agency
- Licensed physician (MD or DO)
- Licensed psychologist (PhD)
- A state hospital operated and maintained by the state of Washington for the care of the mentally ill
- Any other provider listed under the definition of “provider” (see ***Definitions*** in this booklet) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of their license.
- Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care.
- Washington state-licensed Behavioral Health Agency

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

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

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

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

The Mental Health Care benefit doesn't cover:

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

Neurodevelopmental Therapy (Habilitation)

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

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

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

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

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

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

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

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

This benefit doesn't cover:

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

Newborn Care

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To continue benefits beyond the 3-week period, see the dependent eligibility and enrollment guidelines outlined in ***Medical Plan Eligibility And Enrollment***.

If the mother isn't eligible to receive obstetrical care benefits under this plan, the newborn isn't automatically covered for the first 3 weeks. For newborn enrollment information, see ***Medical Plan Eligibility And Enrollment***.

You must add your newly adopted child to your health plan for enrollment in this plan. This is not automatic. If adding the child increases the premium, the required forms must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. See ***Medical Plan Eligibility And Enrollment*** section.

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

Hospital Care

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

Professional Care

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

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

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

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

Orthognathic Surgery (Jaw Augmentation Or Reduction)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) are provided. Covered orthognathic services include surgery for repair of a dependent child's congenital (apparent at birth) deformities determined to be medically necessary

Prescription Drug

What's Covered

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

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

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

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

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

Formulary Drug List

This benefit uses a specific list of covered prescription drugs, sometimes referred to as a "formulary drug list". Our Pharmacy and Therapeutics Committee, which includes providers and pharmacists from the community, frequently reviews current medical studies and pharmaceutical information. The Committee makes

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

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

Diabetic Drugs

Shots You Give Yourself

- Prescribed drugs for shots that you give yourself, such as insulin. Your cost shares for covered prescription insulin drugs will not exceed $35 per 30-day supply of the drug, not subject to deductible, if any. Cost shares for covered prescription insulin drugs apply towards the deductible, if any.
- Needles, syringes, alcohol swabs, test strips, testing agents and lancets.

Prescribed Asthma Inhalers for the treatment of asthma. Your cost shares for covered prescription asthma inhalers for at least one covered inhaled corticosteroid and at least one covered inhaled corticosteroid combination that is FDA approved for the treatment of asthma will not exceed $35 per 30-day supply of the drug, not subject to deductible, if any. Cost shares for covered prescription asthma inhalers apply towards the deductible, if any.

Prescribed Epinephrine Autoinjectors for the treatment of allergic reaction. Your cost shares for at least one covered epinephrine autoinjector product containing at least two autoinjectors will not exceed $35, not subject to deductible, if any. Cost shares for covered prescription epinephrine autoinjectors apply towards the deductible, if any.

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

Oral Chemotherapy This benefit covers drugs you can take by mouth that can be used to kill cancer cells or slow their growth. This benefit only covers the drugs that you get from a pharmacy.

Glucagon and Allergy Emergency Kits

Prescription Vitamins

Human growth hormone Human growth hormone is covered only for medical conditions that affect growth. It is not covered when the cause of short stature is unknown. Human growth hormone is a specialty drug. It is not covered under other benefits of this plan.

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

Contraceptives

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

Preventive Drugs Required By The Affordable Care Act that your provider prescribes. Some preventive drugs have limits on how often you and/or who should get them. The limits are often based on your age or gender. After one of these limits is reached, these drugs are not covered in full and you may have to pay more out-of-pocket costs.

Off-Label Uses The US Food and Drug Administration (FDA) approves prescription drugs for specific health conditions or symptoms. Some drugs are prescribed for uses other than those the FDA has approved. The plan covers such drugs if the use is recognized as effective in standard drug reference guides put out by the American Hospital Formulary Service, the American Medical Association, the US Pharmacopoeia, or other reference guides also recognized by the Federal Secretary of the US Health and Human Services department or the Insurance Commissioner.

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

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

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

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

Pharmacy	Supply Limit	Instructions
In-Network Retail or In-Network Specialty Pharmacies	30 days	Pay the cost share in the ***Summary Of Your Costs*** at the pharmacy
Out-Of-Network Retail Pharmacies	30 days	• Pay the full cost of the drug at the pharmacy. • Send Premera a claim. See ***How Do I File A Claim?*** in this booklet for instructions.
In-Network Mail-Order Pharmacy (Out-of-network mail-order pharmacies are not covered)	90 days	• Allow 2 weeks for your prescription to be filled. • Ask your provider to prescribe up to a 90-day supply of the drug you need. • Send your prescriptions and a pharmacy mail-order form to the mail-order pharmacy. You can download the form from our website or call us for a copy. Our website and phone numbers are on the back cover of this booklet.

Exclusions

This benefit does not cover:

- Over-the-counter drugs and supplies, even if you have a prescription, that are not listed as covered above. For example, the plan does not cover vitamins, food and dietary supplements (such as baby formula or protein powder), or herbal or naturopathic medicines.
- Drugs used to improve your looks, such as drugs to increase hair growth
- Drugs for experimental or investigational use. (See ***Definitions***.)
- Blood or blood derivatives. See the ***Blood Products And Services*** benefit for coverage.
- More refills than the number prescribed, or any refill dispensed more than one year after the prescriber's original order
- Drugs for use while you are in a health care facility or provider's office, or take-home drugs dispensed and billed by a health care facility. The exceptions are for specialty drugs.
- Replacement of lost or stolen items
- Solutions and drugs that you get through a shot or through an intravenous needle, a catheter or a feeding tube. (The exception is a shot you give yourself.) See the ***Infusion Therapy*** benefit.
- Drugs to treat sexual dysfunction
- Drugs to manage your weight
- Medical equipment and supplies that are not listed as covered above. See the ***Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies*** benefit for coverage.
- Immunization agents and vaccines. See the ***Preventive Care*** benefit.
- Drugs for fertility treatment or assisted reproduction procedures.

Your Prescription Drug Rights

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

Questions and Answers About Your Pharmacy Benefits

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

Essentials Drug List

This benefit makes use of our Essentials drug list, sometimes referred to as a "formulary."

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

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

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

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

Generic Drug Substitution

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. If your prescriber does not want to substitute a generic for the brand name drug, you pay only the applicable brand name cost shares. See the ***Summary Of Your Costs*** for the amount you pay. However, if the prescriber allows you to take the generic drug instead of the brand-name drug, and you buy the brand name drug anyway, you will have to pay the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost share. Please ask your pharmacist about the higher costs you will pay if you select a brand name drug. **Important note:** If the generic drug is not effective, you may request a review for medical necessity and consideration to waive the difference in cost between the brand name drug and the generic equivalent. You will still be responsible for paying the applicable brand name drug cost share.

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

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

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

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

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

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

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

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

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

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

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

Our Pharmacy and Therapeutics Committee reviews the pharmacy drug list frequently throughout the year. It can decide to make a drug preferred or non-preferred at any point in the year. The committee may also add or remove a drug from the Essentials drug list during the year. These changes can happen if new drugs appear on the market or new medical studies or other clinical information warrant the change.

If you're taking a drug that's changed from preferred to non-preferred status, we'll notify you before the change. We will also tell you if a drug you are taking is going to be removed from the Essentials drug list. The amount you pay for a drug is based on whether the generic, brand name or specialty drug is preferred or non-preferred on the date it is dispensed. Whether the pharmacy is in the network or not on the date the drug is dispensed is also a factor.

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

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

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

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

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

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

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

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

You can find an in-network pharmacy near you by consulting your provider directory, or calling the Pharmacy Locator Line at the toll-free telephone number found on the back of your ID card.

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

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

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

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

- The number of units and days' supply dispensed on the last refill
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill. This rule does not apply when the member has purchased more than a 180-day supply of contraceptive drugs at one time.

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

- A pharmacist can approve an early refill of a prescription for eye drops or eye ointment in some cases. If you must pay a copay for the drug, the full copay is required for the early refill.
- A different supply can be allowed so that a new drug can be refilled at the same time as drugs that you are already taking. We will pro-rate the cost shares to the exact number of days early that the refill is dispensed. For example, a drug with a $10 copay for a 30-day supply would have a per-day copay of 33 cents. If the member needed a 20-day supply of the drug, we would then multiply the 33 cents by 20.
- You can ask for up to a 12-month supply of contraceptive drugs. If you have a copay for the drug, you must pay one copay for each 30-day supply from a retail pharmacy or one copay for each 90-day supply from the in-network mail-order pharmacy.

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

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

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

Drug Discount Programs

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

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

Preventive Care

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

Preventive Exams

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

Immunizations

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

Screening Tests

Routine lab tests and imaging, this includes women's preventive services as recommended by the Health Resources and Services Administration (HRSA) women's preventive services guidelines and others such as:

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

Pregnant Member's Care

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

Colorectal Cancer Screening

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

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

Diabetes Preventive Program

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

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

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

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

See the ***Chronic Condition Management*** for additional diabetes benefit information.

Diabetes Screening

Health Education and Training

Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma. The program or class must have our approval.

Nicotine Habit-Breaking Programs

Programs to stop smoking, chewing tobacco or taking snuff. Information regarding available nicotine habit-breaking programs can be obtained by contacting your provider.

Nutritional Counseling and Therapy

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

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

Fall Prevention

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

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

Post-exposure prophylaxis (PEP)

Contraceptives

- Contraceptive devices, shots and implants. The plan will cover up to a 12-month supply of contraceptive pills.

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

About Preventive Care

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

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

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

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

Some preventive services and tests have limits on how often you should get them. The limits are often based on your age or gender. For some services, the number of visits covered as preventive depends on your medical needs. After one of these limits is reached, these services are not covered in full and you may have to pay more out-of-pocket costs.

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

For example:

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

The *Preventive Care benefit* does not cover:

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

- Physical exams for basic life or disability insurance
- Work-related disability or medical disability exams
- Purchase of hospital-grade breast pumps
- Vasectomy. See ***Surgery***.

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

Professional Visits And Services

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

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (See ***Definitions***)
- Repair of a dependent child's congenital anomaly
- Consultations with a pharmacist
- Real-time visits via online and telephonic methods with your doctor or other provider who also maintains a physical location.

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

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

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

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

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

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

Electronic Visits

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

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

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

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

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

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services
- Rehabilitation that is not part of a cardiac or pulmonary rehabilitation program. See ***Rehabilitation Therapy***.

Psychological and Neuropsychological Testing

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

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

Rehabilitation Therapy

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

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

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

Cardiac rehabilitation, pulmonary rehabilitation and chronic pain care are covered as any other medical condition and do not accrue to rehabilitation therapy limits.

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

Inpatient Care

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

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

Outpatient Care

This benefit covers the following types of medically necessary outpatient therapy:

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

This benefit does not cover:

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

Skilled Nursing Facility Care

This benefit includes:

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

- Active supervision by your provider while in the skilled nursing facility

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

This benefit does not cover:

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

Spinal and Other Manipulations

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

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

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

Substance Use Disorder

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

Covered services include services provided by a state-approved treatment program or other licensed or certified provider. Covered outpatient visits can include real-time visits via telephone, online chat or text, or other electronic methods with your doctor or other provider who also maintains a physical location.

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

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

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

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

Surgery

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

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

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

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

For members residing in states where laws prohibit access to medically necessary gender affirming care, travel to a provider in another state may be covered. See ***Medical Transportation – State-Restricted Care*** for details.

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

Surgical Center Care – Outpatient

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

Temporomandibular Joint Disorders (TMJ) Care

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

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

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

This benefit covers:

- Exams
- Consultations
- Treatment

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

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

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

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

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

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

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

Therapeutic Injections

This benefit covers:

- Shots given in the provider’s office
- Supplies used during the visit, such as serums, needles and syringes

- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

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

Transplants

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

Covered Transplants

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

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

  The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:

  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney
  - Pancreas
  - Pancreas with kidney
  - Bone marrow (autologous and allogeneic)
  - Stem cell (autologous and allogeneic)

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

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

Recipient Costs

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

Donor Costs

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

Travel And Lodging

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

The Transplants benefit doesn't cover:

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

Urgent Care

This benefit covers services, such as:

Exams and treatment of:

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

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

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

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

Virtual Care

Virtual care uses interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. 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

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

Weight Management

Non-Surgical Weight Management

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

Non-surgical weight management benefits include, but aren't limited to, coverage of the following outpatient medical services:

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

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

Surgical Weight Loss Treatment

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

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

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

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

To qualify for surgical weight loss treatment, the member must meet the three criteria stated in the Claims Administrator's medical policy on bariatric surgery. See the Bariatric Surgery medical policy at www.premera.com. A summary of the criteria is shown below:

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

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

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

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

The *Weight Management* benefit does not cover:

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

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

OUT-OF-AREA CARE

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

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

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

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

BlueCard Program

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

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

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

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

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

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

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

Taxes, Surcharges and Fees

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

Non-Contracted Providers

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

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

Blue Cross Blue Shield Global® Core

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

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

More Questions

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

CARE MANAGEMENT

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

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

PRIOR AUTHORIZATION

You must get Premera's approval for some services before the service is performed. This process is called prior authorization.

There are two different types of prior authorization required:

1. **Prior Authorization For Benefit Coverage** You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays. This is so that Premera can confirm that these services are medically necessary and covered by the plan.
2. **Prior Authorization For In-Network Cost shares For Out-Of-Network Providers** You must get prior authorization in order for an out-of-network provider to be covered at the plan's in-network benefit level, except for emergency services. See ***Exceptions To Prior Authorization For Out-of-Network Providers*** below for more information.

How Prior Authorization Works

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

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

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

Prior Authorization for Benefit Coverage

Medical Services, Supplies or Equipment

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

- **In-network providers or facilities** are required to request prior authorization for the service.
- **Out-of-network and out-of-area providers and facilities** will not request prior authorization for the service. You have to ask Premera to prior authorize the service.

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

Prescription Drugs

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

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

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

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

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

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

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

Exceptions To Prior Authorization For Benefit Coverage

The following services do not require prior authorization for benefit coverage, but they do have separate requirements:

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

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

Prior Authorization For Out-Of-Network Provider Coverage

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

Note: It is your responsibility to get prior authorization for any services that require it when you see a provider that is out-of-network. If you do not get a prior authorization, the services will not be covered at the in-network benefit level.

The prior authorization request for an out-of-network provider must include the following:

- A statement explaining how the provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from an in-network provider, and
- Medical records needed to support the request.

If the out-of-network services are authorized, the plan will cover the service at the in-network benefit level.

However, in addition to the cost shares, you may pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Amounts over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.

Exceptions to Prior Authorization For Out-Of-Network Providers

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

If you are admitted to an out-of-network hospital due to an emergency condition, those services are always covered at the in-network benefit level. The plan will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital.

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

CLINICAL REVIEW

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

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

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

PERSONAL HEALTH SUPPORT PROGRAMS

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

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

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

CHRONIC CONDITION MANAGEMENT

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

Diabetes Management

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

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

Diabetes Prevention

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

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

EXCLUSIONS AND LIMITATIONS

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

Amounts Over The Allowed Amount

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

Assisted Reproduction

Assisted reproduction technologies such as:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures.
- Artificial insemination or 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 other types of insurance or coverage, such as:

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

Benefits that have been exhausted

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

Broken or missed appointments

Broken or missed appointments, including charges from providers for broken or missed appointments.

Caffeine Dependency

Charges For Records or Reports

Charges from providers for supplying records or reports that aren't requested by Premera for utilization review.

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

Drugs, services or supplies for cosmetic services. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This does not apply to services that are determined to be medically necessary for Gender Affirming Care.

Counseling, Education or Training

Counseling, education or training in the absence of illness or injury, including but not limited to:

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

Court-Ordered Services

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

Custodial Care

Custodial services that are not covered hospice care services.

Dental Care

Dental care or supplies, that are not covered under any dental benefits. This exclusion also doesn't apply to dental services covered under the ***Temporomandibular Joint Disorders (TMJ) Care*** benefit.

EEG biofeedback or neurofeedback services

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental or Investigational Services

Experimental or investigational services or supplies, including any complications or effects of such services. This does not apply to certain services that are part of an approved clinical trial.

Family Members or Volunteers

Services or supplies that you provide to yourself. It also does not cover a provider who is:

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

Governmental Facilities

Services provided by a state or federal facility that are not emergency services or required by law or regulation.

Hair Analysis

Hair Loss

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

Illegal Acts, Illegal Services and Terrorism

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

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 conditions:

- Ordered when this plan is not in effect or when the person is not covered under this plan
- That are not listed as covered under this plan
- Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay
- Non-treatment charges, including charges for provider time
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping
- Doing housework or chores for the member or helping the member do housework or chores

Non-Diagnostic Testing

Testing required for employment, schooling, screening, or public health purposes.

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing
- Incarceration or
- Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered services. Examples are prisons, nursing homes, juvenile detention facilities.

Orthodontia

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

Personal comfort or convenience items

- Personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport.
- Dietary assistance, including “Meals on Wheels”

Provider’s Licensing Or Certification

Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified providers.

Recreational, Camp and Activity Programs

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

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

Serious Adverse Events and Never Events

Serious Adverse Events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge.

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

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

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

Services or Supplies Not Medically Necessary

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

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of importance or hypoactive sexual desire disorder, including drugs, medications, or penile or other implants.

Vision Exams

Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.

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.

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics, treatment or surgeries to improve the refractive character of the cornea or results of such treatments.

Voluntary Support Groups

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

Work-Related Illness Or Injury

Any illness, condition or injury for which you get benefits under:

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

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

WHAT IF I HAVE OTHER COVERAGE?

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

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

If you are covered by more than one health plan, and if you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

Caution: All health plans have timely filing requirements. If you or your provider fail to submit your claim to a 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 health plan within its claim filing time limit to prevent a denial of the claim.

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

COB Definitions

For the purposes of COB:

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

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

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

Primary And Secondary Rules

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

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

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

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

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

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

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

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

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

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

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

COB's Effect On Benefits

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

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. **When paying a claim, the total amount paid by the secondary plan in combination with what is paid by the primary plan is never required to be more than one hundred percent of the highest total allowable expense of either plan, plus any savings accrued from prior claims incurred in the same calendar year.**

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

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

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

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

Right Of Recovery/Facility Of Payment

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.

SUBROGATION AND REIMBURSEMENT

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

Definitions The following terms have specific meanings in this contract:

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

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

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

Medical Plan Eligibility and Enrollment

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

Eligibility for Subscribers and Dependents

School Employee Eligibility

The school employee’s SEBB organization will inform the school employee in writing whether or not they are eligible for SEBB benefits upon employment and whenever their eligibility status changes. The written notice will include information about the school employee’s right to appeal eligibility and enrollment decisions.

A school employee of an employer group (such as an employee organization representing school employees or a tribal school) that contracts with HCA for SEBB benefits should contact their payroll or benefits office for eligibility criteria.

School employees have the right to appeal eligibility and enrollment decisions. Information about appeals can be found under "Appeal rights."

Continuation Coverage Eligibility

The SEBB Program determines whether subscribers are eligible for continuation coverage (COBRA or Unpaid Leave) upon receipt of their election to enroll in *SEBB Continuation Coverage (COBRA or Unpaid Leave)*. If the subscriber requests to enroll in and is not eligible for continuation coverage, the SEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

School board member eligibility

The SEBB Program determines whether a school board member is eligible to self-pay coverage upon receipt of their election to enroll. If a school board member requests to enroll and is not eligible, the SEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

Dependent Eligibility

The following are eligible dependents:

- Legal spouse
- State-registered domestic partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability." Children are defined as the subscriber's:
    - **Children based on establishment of a parent-child relationship,** as described in Washington State statutes, except when parental rights have been terminated.
    - **Children of the subscriber's spouse,** based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
    - **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
    - **Children of the subscriber's state-registered domestic partner,** based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.
    - **Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage.**
    - **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.** The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.
    - **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:

- The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
- The subscriber must notify the SEBB Program in writing when the child is no longer eligible under this subsection.
- A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
- A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.
- The SEBB Program, with input from the medical plan, will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

Enrollment for Subscribers and Dependents

For all Subscribers and Dependents

- To enroll at any time other than during the initial enrollment period, see "Making changes."
- Any dependents enrolled in medical coverage will be enrolled in the same medical plan as the subscriber.

School Employee Enrollment

A school employee must use the SEBB My Account online enrollment system or Benefits 24/7 (once available) or submit a *School Employee Enrollment or School Employee Enrollment (for Medical Only Groups)* form and any supporting documents to their SEBB organization or employer group when they become newly eligible or regain eligibility for SEBB benefits. The online enrollment must be completed or the form must be received no later than 31 days after the date the school employee becomes eligible or regains eligibility.

If the school employee does not enroll online or return the form by the deadline, the school employee will be enrolled in Uniform Medical Plan Achieve 1 and a tobacco use premium surcharge will be incurred. Consequently, dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment for enrolling a dependent.

Waiving Medical Enrollment

An eligible school employee may waive enrollment in SEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. They may not waive enrollment in SEBB medical if they are enrolled in Public Employees Benefits Board (PEBB) retiree insurance coverage. When a retiree becomes eligible for the employer contribution toward SEBB benefits, PEBB retiree insurance coverage will be automatically deferred.

If a school employee waives enrollment in SEBB medical, the school employee cannot enroll eligible dependents. For information on when an eligible school employee may waive SEBB medical after their initial enrollment period, or to enroll after having waived, see "Making changes."

Continuation Coverage Enrollment

A subscriber enrolling in SEBB Continuation Coverage (COBRA or Unpaid Leave) may enroll by using benefits 24/7, the online enrollment system (once available), or by submitting the applicable *SEBB Continuation Coverage Election/Change* form and any supporting documents to the SEBB Program. The SEBB Program must receive the election form no later than 60 days from the date the enrollee's SEBB health plan coverage ended or from the postmark date on the *SEBB Continuation Coverage Election Notice* sent by the SEBB Program, whichever is later.

Premiums and applicable premium surcharges associated with continuing SEBB medical must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see "Options for continuing SEBB medical coverage" and the *SEBB Continuation Coverage Election Notice.*

School board member enrollment

A school board member is required to enroll in a medical plan.

A newly elected school board member may enroll and self-pay premiums by submitting the *SEBB School Board Member Election/Change* form and any supporting documents to the SEBB Program. The SEBB Program must receive the form no later than 60 days from the beginning of their elected or appointed term.

Premiums and applicable premium surcharges associated with continuing SEBB medical must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above.

A school board member may renew their participation at the start of each subsequent term as a school board member. If a school board member is reelected for a new term consecutive from their previous term, they will not be required to make new elections.

Dependent Enrollment

To enroll an eligible dependent, the subscriber must include the dependent's information online using SEBB My Account or benefits 24/7 (once available), or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in SEBB health plan coverage if the SEBB Program, the SEBB organization, or the employer group is unable to verify their eligibility within the SEBB Program enrollment timelines.

National Medical Support Notice (NMSN)

When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child, the following provisions apply:

The subscriber may enroll their dependent child and request changes to their health plan coverage as described under "Changes to health plan coverage or enrollment are allowed as directed by the NMSN," below.

- **A school employee** must use the SEBB My Account online enrollment system or Benefits 24/7 (once available) or submit the required form(s) to their SEBB organization or employer group.
- **Any other subscriber** must use Benefits 24/7 (once available) or submit the required form(s) to the SEBB Program.

If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the SEBB organization, the employer group, or the SEBB Program may make enrollment or health plan coverage changes according to "Changes to health plan coverage or enrollment are allowed as directed by the NMSN," below, upon request of:

- The child's other parent.
- A child support enforcement program.

Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

a) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN.

b) A school employee who has waived SEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent.

c) The subscriber's selected health plans will be changed if directed by the NMSN.

d) If the dependent is already enrolled under another SEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.

e) If the dependent is enrolled in both SEBB medical and Public Employees Benefits Board (PEBB) medical as a dependent and there is an NMSN in place, enrollment will be in accordance with the NMSN.

f) If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

Changes to health plan coverage or enrollment as described above in (a) through (c) will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day.

A dependent will be removed from the subscriber's health plan coverage as described above in (d) the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

When a NMSN requires a subscriber's spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in the subscriber's SEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's SEBB health plan coverage prospectively.

Dual Enrollment

A subscriber and their dependents may each be enrolled in only one SEBB medical plan.

A school employee or their dependent who is eligible to enroll in both the SEBB Program and the Public Employees Benefits Board (PEBB) Program is limited to a single enrollment in either the SEBB or PEBB Program.

For example:

- A child who is an eligible dependent under two parents enrolled in SEBB Program benefits may be enrolled as a dependent under both parents but is limited to a single enrollment in SEBB medical.
- A child who is an eligible dependent of a school employee in the SEBB Program and an employee in the PEBB Program may only be enrolled as a dependent under one parent in either the SEBB or PEBB Program.

Medicare Eligibility and Enrollment

School Employee and Dependent

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

A school employee or their dependent are deemed eligible for Medicare when they have the option to receive Medicare Part A benefits. If a school employee or their dependent chooses to enroll in Medicare Part A, Medicare regulations and guidelines will determine whether Medicare is the primary or secondary payer.

A school employee or their dependent who is enrolled in Medicare may remain enrolled in SEBB medical coverage. However, a school employee may choose to waive their SEBB medical coverage or remove their dependent from their SEBB medical coverage and choose Medicare as their primary insurer. If a school employee does so, neither the school employee nor their dependent can enroll in SEBB medical except during the annual open enrollment or a special open enrollment.

In most situations, a school employee and their dependent can defer Medicare Part B enrollment without a penalty while enrolled in SEBB medical coverage. When the school employee terminates employment, the school employee and the dependent can enroll in Medicare Part B during a Special Enrollment Period. If Medicare eligibility is due to a disability, the school employee or their dependent must contact the Social Security Administration about deferring enrollment in Medicare Part B.

Upon retirement, Medicare will become the primary insurance payer, and the PEBB medical plan will become secondary. See "PEBB retiree insurance coverage."

Continuation Coverage Subscriber, a School Board Member, or their and Dependent

If a continuation coverage subscriber, a school board member or their dependent becomes eligible for Medicare, federal regulations allow enrollment in Medicare three months before they turn age 65. If they do not enroll within three months before the month they turn age 65, enrollment in Medicare may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first eligible, a late enrollment penalty may apply.

A SEBB Continuation Coverage (COBRA) subscriber must notify the SEBB Program in writing within 30 days if, after electing SEBB Continuation Coverage (COBRA), a subscriber or their dependent becomes eligible for Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. If a subscriber or their dependent enrolls in SEBB Continuation Coverage (COBRA) and then becomes eligible for Medicare, their enrollment in SEBB Continuation Coverage (COBRA) will be terminated at the end of the month in which they become eligible for Medicare due to turning age 65 or older or when enrolled in Medicare due to a disability. This may cause the SEBB Continuation Coverage (COBRA) to be terminated early, before the subscriber has used all the months they would otherwise be entitled to. A subscriber or their dependent who are already enrolled in Medicare when they enroll in SEBB Continuation Coverage (COBRA) will not have their coverage terminated early.

When Medical Coverage Begins

School Employees and Dependents

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

Exceptions:

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

For a school employee regaining eligibility, including following a period of leave as described in SEBB Program rules, and their eligible dependents, medical coverage begins the first day of the month following the school employee's return to work if the school employee is anticipated to be eligible for the employer contribution.

Note: When a school employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they return from active duty. Medical coverage begins the first day of the month in which the school employee returns from active duty.

Continuation Coverage Subscriber and Dependents

For a continuation coverage subscriber and their eligible dependents enrolling when newly eligible due to a qualifying event, medical coverage begins the first day of the month following the day they lost eligibility for SEBB medical plan coverage.

School board members and dependents

For a newly elected or appointed school board member and their eligible dependents, medical coverage begins the first day of the month following the day the SEBB Program receives the required form.

All Subscribers and Dependents

For a subscriber or their eligible dependents enrolling during the SEBB Program's annual open enrollment, medical coverage begins January 1 of the following year.

For a subscriber or their eligible dependents enrolling during a special open enrollment, medical coverage begins the first day of the month following the later of the event date or the date the online enrollment election using SEBB My Account or benefits 24/7 (once available), or the required form is received. If that day is the first of the month, medical coverage begins on that day.

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

- **For a school employee,** medical coverage will begin the first day of the month in which the event occurs.
- **For a newly born child,** medical coverage will begin the date of birth.
- **For a newly adopted child,** medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.
- **For a spouse or state-registered domestic partner** of a subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of **an extended dependent or a dependent child with a disability**, medical coverage will begin the first day of the month following the event date or eligibility certification, whichever is later.

Making Changes

Removing a dependent who is no longer eligible

A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child as described under "Dependent eligibility." The notice must be received within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

- **A school employee** must provide notice online using SEBB My Account or Benefits 24/7 (once available), or by submitting a written request to their SEBB organization or employer group.
- **Any other subscriber** must provide notice online using Benefits 24/7 (once available) or by submitting a written request to the SEBB Program.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue SEBB medical coverage under one of the continuation coverage options described in "Options for continuing SEBB medical coverage."
- The subscriber may be billed for claims paid by the medical plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.
- The subscriber may be responsible for premiums paid by the state for the dependent's medical plan coverage after the dependent lost eligibility.

Voluntary termination for continuation coverage subscribers or school board members

A continuation coverage subscriber or school board members may voluntarily terminate enrollment in a medical plan at any time by submitting a request online using Benefits 24/7 (once available) or in writing to the SEBB Program. Enrollment in the medical plan will be terminated the last day of the month in which the request was received online or by the SEBB Program or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

Note: A school board member must be enrolled in all SEBB health plan coverage, including SEBB medical, SEBB dental, and SEBB vision. A school board member who voluntarily terminates enrollment in a medical plan also terminates all other health plan enrollment.

Making changes during annual open enrollment and special open enrollment

A subscriber may make certain changes to their enrollment during the annual open enrollment and if a specific life event creates a special open enrollment period.

Annual Open Enrollment Changes

A school employee may make the following changes to their enrollment during the SEBB Program's annual open enrollment period:

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

A school employee must submit the election change online using SEBB My Account or Benefits 24/7 (once available) or submit the required *School Employee Change* form and any supporting documents to their SEBB organization or employer group. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period and will be effective January 1 of the following year.

Any other subscriber may make the following changes to their enrollment during the SEBB Program's annual open enrollment period:

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

They must submit the election change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage Election/Change* or *SEBB School Board Member Election/change* form (as appropriate) and any supporting documents to the SEBB Program. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period. The change will be effective January 1 of the following year.

Special Open Enrollment Changes

A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

A special open enrollment event must be other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits. The subscriber must provide evidence of the event that created the special open enrollment.

A special open enrollment may allow a subscriber to make the following changes:

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

To request a special open enrollment:

- **A school employee** must make the change online using SEBB My Account or Benefits 24/7 (once available) or submit the required *School Employee Change form* and any supporting documents to their SEBB organization or employer group.
- **Any other subscriber** must make the change online using Benefits 24/7 or submit the required *SEBB Continuation Coverage Election/Change or SEBB School Board Member Election/Change* form (as appropriate) and any supporting documents to the SEBB Program.

The change must be completed online, or the forms must be received no later than 60 days after the event that creates the special open enrollment. In addition, the SEBB Program, the SEBB organization, or the employer group will require the subscriber to provide proof of a dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception: If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in SEBB health plan coverage, the subscriber should complete the request online or notify their SEBB organization, their employer group, or the SEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required forms must be received, no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan during a special open enrollment if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.

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

- Subscriber gains a new dependent due to:
    - Marriage or registering a state-registered domestic partnership.
    - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber has a change in employment location that affects medical plan availability. If the subscriber changes employment locations and their current medical plan is no longer available, the subscriber must select a new medical plan as described in SEBB Program rules. If the subscriber does not elect a new medical plan as required, they will be enrolled in a SEBB medical plan designated by the director of HCA or their designee. If the subscriber has one or more new medical plans available, the subscriber may select to enroll in a newly available plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan, as described in SEBB Program rules. If the subscriber does not elect a new medical plan as required, they will be enrolled in a SEBB medical plan designated by the director of HCA or their designee.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependents enrollment in Medicare, the subscriber must select a new medical plan.

- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber or dependent's physician stops participation with the subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but not limit its consideration to the following:
    - Active cancer treatment, such as chemotherapy or radiation therapy
    - Treatment following a recent organ transplant
    - A scheduled surgery
    - Recent major surgery still within the postoperative period
    - Treatment for a high-risk pregnancy
- The SEBB Program determines that there has been a substantial decrease in the providers available under a SEBB medical plan.

Note: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the SEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the SEBB Program determines that a continuity of care issue exists or there has been a substantial decrease in the providers available under the plan.

Special open enrollments events that allow adding or removing a dependent

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

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

- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.

Special open enrollment events that allow waiving medical enrollment and enrolling after waiving

A school employee may waive SEBB medical during a special open enrollment if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. A school employee may not waive enrollment in SEBB medical if they are enrolled in PEBB retiree insurance coverage.

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

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

When Medical Coverage Ends

Termination dates

Medical coverage ends on the following dates:

- On the last day of the month when any enrollee ceases to be eligible. For a school board member this includes when their elected or appointed term ends.
- On the date a medical plan terminates due to a change in contracted service area or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another SEBB medical plan.

- **For a school employee** and their dependents when the employment is terminated, medical coverage ends when:
  - The school employee resigns. If this is the case, medical coverage ends on the last day of the month in which a school employee's resignation is effective; or
  - The SEBB organization or the employer group terminates the employment relationship. If this is the case, medical coverage ends on the last day of the month in which the employer-initiated termination is effective.

Note: If the SEBB organization or the employer group deducted the school employee's portion of the premium for SEBB insurance coverage after the school employee was no longer eligible for the employer contribution, medical coverage ends the last day of the month for which school employee premiums were deducted.

- **For a continuation coverage subscriber** or a school board member who submits a request to terminate medical coverage, enrollment in medical coverage will be terminated the last day of the month in which the request was received online using Benefits 24/7 (once available) or by the SEBB Program or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical coverage will be terminated on the last day of the previous month.

A subscriber will be responsible for payment of any services received after the date medical coverage ends as described above.

Final Premium Payments

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their medical plan before the end of the month.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, the account will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance and applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, the subscriber's medical coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid.

If An Enrollee is Hospitalized

An enrollee who is receiving covered services in a hospital on the date medical coverage ends will continue to be eligible for covered services while an inpatient for the condition which the enrollee was hospitalized, until one of the following events occur:

- According to this plan's clinical criteria, it is no longer medically necessary for the enrollee to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The enrollee becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The enrollee becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the enrollee is eligible for SEBB Continuation Coverage as described in "Options for continuing SEBB medical coverage."

Options for Continuing SEBB Medical Coverage

When medical coverage ends, the subscriber and their dependents covered by this medical plan may be eligible to continue SEBB medical coverage during temporary or permanent loss of eligibility.

There are three options the subscriber and their dependents may qualify for when coverage ends.

- SEBB Continuation Coverage (COBRA)

- SEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage

A subscriber also has the right to convert to individual medical insurance coverage with the plan when continuation of group medical insurance coverage is no longer possible.

SEBB Continuation Coverage

The SEBB Program administers the following continuation coverage options to temporarily extend group insurance coverage when the enrollee's SEBB medical plan coverage ends due to a qualifying event:

- **SEBB Continuation Coverage (COBRA)** includes eligibility and administrative requirements under federal COBRA laws and regulations. Some enrollees who are not qualified beneficiaries under federal COBRA, may also qualify for SEBB Continuation Coverage (COBRA).
- **SEBB Continuation Coverage (Unpaid Leave)** is an option created by the SEBB Program with wider eligibility criteria and qualifying event types than COBRA.

An enrollee who qualifies for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may enroll in only one of these options. See "Continuation coverage enrollment" and the *SEBB Continuation Coverage Election Notice.*

Premium payments for SEBB Continuation Coverage

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges.

PEBB Retiree Insurance Coverage

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

Transitional Continuation Coverage

Non-represented educational service district (ESD) school employees and their dependents may gain temporary eligibility for SEBB benefits, on a self-pay basis, if they meet the following criteria:

- A non-represented ESD school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB organization on December 31, 2023, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to continue existing enrollment in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of 18 months.
- A dependent of a SEBB eligible non-represented school employee of an ESD who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2023, who loses eligibility because they are not an eligible dependent may continue existing enrollment for a maximum of 36 months.
- A dependent of a non-represented school employee who is continuing medical, dental, or vision coverage through an ESD on December 31, 2023, may elect to continue existing enrollment to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program.

Family and Medical Leave Act of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the federal FMLA.

The SEBB organization or the employer group determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under FMLA, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no

contribution from the SEBB organization or the employer group. See “Options for continuing SEBB medical coverage.”

Paid Family and Medical Leave Act

A school employee on approved leave under the Washington State Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward SEBB benefits.

The Employment Security Department determines if the school employee is eligible for leave under PFML. The school employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under PFML, they may continue SEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the SEBB organization or the employer group. See “Options for continuing SEBB medical coverage.”

Conversion of Coverage

An enrollee has the right to switch from SEBB group medical to an individual conversion plan offered by this plan when they are no longer eligible to continue the SEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care.

An enrollee must apply for conversion coverage and pay the first month’s premium no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of this conversion plan differ from those of the enrollee’s current group medical plan. To receive detailed information on conversion options under this medical plan, call us at 1-800-807-7310 (TRS: 711).

General provisions for eligibility and enrollment

Payment of premiums during a labor dispute

Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB organization or the employer group may pay premiums directly to HCA if the school employee’s compensation is suspended or terminated directly or indirectly because of a strike, lockout, or any other labor dispute, for a period not to exceed six months.

When the school employee’s compensation is suspended or terminated, HCA will notify the school employee immediately, by mail at the last address of record, that the school employee may pay premiums as they become due.

If coverage is no longer available to the school employee under this certificate of coverage, then the school employee may be eligible to purchase an individual medical plan from this plan consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Appeal rights

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

Any current or former school employee of an employer group that contracts with HCA for SEBB benefits, or their dependent may appeal a decision made by an employer group regarding SEBB eligibility, enrollment, or premium surcharges to the employer group.
Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or premium surcharges to the SEBB Appeals Unit.

Any enrollee may appeal a decision regarding the administration of a SEBB medical plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Learn more at hca.wa.gov/sebb-appeals.

Relationship to law and regulations

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

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Contract Termination

Termination of the Group Contract for this plan completely ends all members' coverage and all our obligations.

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.

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

Many providers will submit their bills to us directly. However, if you need to submit a claim for medical benefits to us, follow the simple steps below.

Step 1

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

Step 2

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

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

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

Prescription Drug Claims

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

In-Network Pharmacies

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

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

Out-Of-Network Pharmacies

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

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

Timely Filing

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

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

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

COMPLAINTS AND APPEALS

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

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

What is a Complaint?

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

How to file a complaint

Call customer service at 800-807-7310 (TRS:711)

Send a fax to 425-918-5592

Send the details in writing to:

Premera Blue Cross

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 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 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. It also includes denials of drugs not on the plan's formulary drug list. (See ***Prescription Drug*** for details

APPEAL LEVELS

You have the right to two levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
External	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	180 days from the date you were notified of our Level 1 appeal decision. OR 180 days from the date 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/sebb** or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-807-9701 (TRS:711)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **premera.com/sebb**. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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

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

Premera Blue Cross

Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111

Fax: 425-918-5592

Appeal Response Time Limits

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

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 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

For all other Level 1 and/or experimental and investigational appeals, we can extend the time limits. If we need more time beyond the appeal required timeframes, we will notify you and ask for your written agreement to a new response date.

WHAT IF YOU HAVE ONGOING CARE

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

If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, the plan will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved. If our decision is upheld, you must repay all amounts the plan paid for ongoing care during the appeal review.

WHAT IF IT'S URGENT

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/sebb** or call customer service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.

Step 3. **Send in my external review request**	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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

ONCE THE IRO DECIDES

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

If the IRO:

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

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

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

1-800-562-6900

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

ADDITIONAL INFORMATION ABOUT YOUR COVERAGE

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

You may also ask for the following information:

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

- Use of the health employer data information set (HEDIS) to track performance
- How to replace your ID card. **Note:** If coverage under your plan terminates, your ID card will no longer be valid.

If you want to receive this information, please go to our website. If you don't have access to the Web, please call customer service. Our web address and phone numbers are shown on the back cover of this booklet.

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

You may also ask customer service for more information about:

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

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Entire Contract

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

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

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

Evidence Of Medical Necessity

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

The Group And You

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

Healthcare Providers - Independent Contractors

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

Intentionally False Or Misleading Statements

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

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.

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

Member Cooperation

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

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable.) In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours as applicable.)

Notice Of Information Use And Disclosure

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

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

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

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

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

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

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

Notice Of Other Coverage

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

- Any legal action or claim against another party for a condition or injury for which we provide benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:

- Personal injury protection (PIP)
- Underinsured motorist coverage
- Uninsured motorist coverage
- Any other insurance under which you are or may be entitled to recover compensation

- The name of any other group or individual insurance plans that cover you

Notices

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

Right Of Recovery

We have the right to recover amounts we paid that exceed the amount for which we're liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

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

Right To And Payment Of Benefits

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

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

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

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

Venue

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

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

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

Women's Health and Cancer Rights Act of 1998

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

Workers' Compensation Insurance

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

DEFINITIONS

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

Accidental Injury

Physical harm caused by a sudden, unexpected event at a certain time an place. Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

Adverse Benefit Determination

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

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

Affordable Care Act

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

Ambulatory Surgical Center

A healthcare facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated mainly for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Annual open enrollment

A period of time defined by HCA when a subscriber may change to another health plan offered by the SEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

Applied Behavioral Analysis (ABA)

The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between

environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

Autism Spectrum Disorders

Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, as amended or reissued from time to time.

Benefit

What this plan provides for a covered service. The benefits you get are subject to this plan's cost shares.

Benefit Booklet

Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.

Calendar Year

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

Clinical Trials

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

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

Community Mental Health Agency

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

Complication of Pregnancy

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

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

- Toxemia
- Gestational diabetes
- Hyperemesis gravidarum
- Spontaneous miscarriage or missed abortion
- A disease the mother has during pregnancy that is not caused by the pregnancy. The disease is made worse by pregnancy.

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

Congenital Anomaly

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

Continuation Coverage

The temporary continuation of SEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or SEBB policies.

Cosmetic Services

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

Cost-Share

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

Covered Service

A service, supply or drug that is eligible for benefits under the terms of this Plan.

Custodial Care

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

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

Dependent

An eligible spouse, state-registered domestic partner, child, or other eligible family member as described in the "dependent eligibility" section of this certificate that is enrolled or eligible to be enrolled by this plan under the subscriber's account.

Detoxification

Active medical management of medical conditions due to substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance taken, repeated vital sign monitoring, and use of medication to manage intoxication or withdrawal. Observation without active medical management, or any service that is claimed to be detoxification but does not include active medical management, is not detoxification.

Doctor (also called "Physician")

A state-licensed:

- Doctor of Medicine and Surgery (MD)
- Doctor of Osteopathy (DO)

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

- Chiropractor (DC)
- Dentist (DDS or DMD)
- Optometrist (OD)
- Podiatrist (DPM)
- Psychologist (PhD)
- Nurse (RN and ARNP) licensed in Washington state

Donor Human Milk

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

Effective Date

The date when your coverage under this plan begins..

Eligibility Waiting Period

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

Emergency Medical Condition (also called "Emergency")

A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

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

Emergency Service

- A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services (such as laboratory and radiology 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 woman in active labor, to perform the delivery
- Ambulance transport, as needed, in support of the services above.

Employer group

An employee organization representing school employees and a tribal school as refined in RCW 28A.715.010, obtaining school employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the SEB board.

Endorsement

A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.

Enrollee or Member (also called "You" and "Your")

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

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Experimental/Investigational Services

A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board.
- There is no reliable evidence showing that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies

Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Explanation of Benefits

An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.

Facility (Medical Facility)

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

Group

The employer that is a party to the Group Contract. The Group is responsible for collecting and paying all premiums, receiving notice of additions and changes to employee and dependent eligibility (including determination) and providing such notice to us, and acting on behalf of its employees.

Health Care Authority (HCA)

The Washington State agency that administers the PEBB and SEBB Programs.

Home Health Agency

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

Home Medical Equipment (HME)

Equipment ordered by a healthcare provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as “Durable Medical Equipment” or “DME”.

Hospice

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

Hospital

A healthcare facility that meets all of these criteria:

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

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

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

Illness

A sickness, disease 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.

In-Network Provider

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

Inpatient

Confined in a medical facility as an overnight bed patient.

Lifetime Maximum

The maximum amount that Premera benefit will provide during your lifetime.

Long-term Care Facility

A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.025, or assisted living facility licensed under chapter 18.20 RCW.

Maternity Care

Health services you get during pregnancy (before, during, and after birth) or for any condition caused by pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.

Medically Necessary and Medical Necessity

Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must:

- Agree with generally accepted standards of medical practice;
- Be clinically appropriate, in terms of type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease.
- Not be mostly for the convenience of the patient, physician, or other health care provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" and "Your")

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

Mental Health Condition

A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance use disorder.

Milk Bank

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

Non-Contracted Provider

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

Non-Participating Provider

A provider that is not in one of the provider networks stated in ***How Providers Affect Your Costs*** section or is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

Orthodontia

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

Orthotic

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

Out-Of-Network Provider

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

Outpatient

Treatment received in a setting other than as inpatient in a medical facility.

Outpatient Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures
- It doesn't provide inpatient services or accommodations

Pharmacy Benefit Manager

An entity that contracts with us to administer the ***Prescription Drug*** benefit under this plan.

Plan

The benefits, terms and limitations stated in this contract.

Premiums

The monthly rates we establish as consideration for the benefits offered under this contract.

Prescription Drug

Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

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

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

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

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

Prior Authorization

Prior authorization is a process that requires you or a provider to follow before a service is given, to determine if service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness. You must ask for prior authorization before the service is delivered.

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

Provider

A 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.

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

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

- Acupuncturists (LAc) (in Washington, also called East Asian Medicine Practitioners (EAMP)
- Audiologists
- Chiropractors (DC)
- Counselors
- Dentists (DDS or DMD)
- Denturists
- Dietitians and Nutritionists (D or CD, or CN)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (LMP)
- Midwives
- Naturopathic Physicians (ND)
- Nurses (RN, LPN, ARNP, or NP)
- Nursing Homes
- Occupational Therapists (OTA)
- Ocularists
- Opticians (Dispensing)
- Optometrists (OD)
- Osteopathic Physician Assistants (OPA) (under the supervision of a DO)
- Osteopathic Physicians (DO)
- Pharmacists (RPh)
- Physical Therapists (LPT)
- Physician Assistants (under the supervision of an MD)
- Physicians (M.D.)
- Podiatric Physicians (DPM)
- Psychologists
- Radiologic Technologists (CRT, CRTT, CRDT, CNMT)
- Respiratory Care Practitioners
- Social Workers

- Speech-Language Pathologists

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

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

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

Psychiatric Condition

A condition listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance abuse disorder.

Public Employees Benefits Board (PEBB)

A group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

Public Employees Benefits Board (PEBB) Program

The HCA program that administers PEBB benefit eligibility and enrollment.

Reconstructive Surgery

Is surgery:

- That restores features damaged as a result of injury or illness.
- To correct a congenital deformity or anomaly

Rehabilitation Therapy

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

Rehabilitation services include physical therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a

rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.

School Board Member

The board of directors of a school district as governed by chapter 28A.343 RCW or the board of directors of an educational service district as governed by chapter 28A.310 RCW who is self-paying for SEBB health plan coverage.

School Employees Benefits Board (SEBB)

A group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

School Employees Benefits Board (SEBB) Organization

A public school district or educational service district or charter school established under Washington state statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).

School Employees Benefits Board (SEBB) Program

The program within HCA that administers insurance and other benefits for eligible school employees, eligible dependents, and eligible school board members.

Service Area

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

Services

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

Skilled Nursing Care

Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.

Skilled Nursing Facility

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

Spouse

- An individual who is legally married to the subscriber.
- An individual who is a domestic partner of the subscriber.

Subscriber

A school employee, a school board member, or a continuation coverage enrollee who has been determined eligible and is enrolled in this plan, and is the individual to whom the SEBB Program or We will issue notices, information, requests, and premium bills on behalf of an Enrollee.

Substance Use Disorder Conditions

They are substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away, but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused. Originating site: Hospital, Rural health clinic, federally qualified health center, physician's or other health care providers office, community mental health center, skilled nursing facility, home or renal dialysis center, except an independent renal dialysis center.

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

We, Us and Our

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

Where To Send Claims

MAIL YOUR CLAIMS TO
Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To
Express Scripts
ATTN: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

Contact the Drug Benefit Manager At
1-800-391-9701
www.express-scripts.com

Customer Service

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

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

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

Local and toll-free TRS number:
711

Care Management

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

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

Complaints And Appeals

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

BlueCard

1-800-810-BLUE(2583)

Website

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