



PPO 70% Plan 6000

Heritage Plus 1

100000105

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 specific eligibility, benefits and claims situations. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal, have independent review of our judgment and decisions, or bring a civil lawsuit challenging to any eligibility or claims determinations under the contract, including our exercise of our judgment and expertise.

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

Group Name: WA Farm Bureau Healthcare Trust

Effective Date: October 1, 2017

Group Number: 100000105

Plan: Your Choice (Non-Grandfathered)

Certificate Form Number: WFB70600017YCH

Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator — Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592,
TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:
U.S. Department of Health and Human Services,
200 Independence Ave SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019,
800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the

right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 1-800-842-5357).

አማርኛ (Amharic):

ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአካፋይ እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። በስልክ ቁጥር 800-722-1471 (TTY: 1-800-842-5357) ይደውሉ።

العربية (Arabic):

يحتوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ

800-722-1471 (TTY: 1-800-842-5357)

中文 (Chinese):

本通知有重要的訊息。 本通知可能有關於您透過 Premera Blue Cross

提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 1-800-842-5357)。

Oromoo (Cushite):

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhuma irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 1-800-842-5357) tii bilbilaa.

Français (French):

Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 1-800-842-5357).

Kreyòl ayisyen (Creole):

Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 1-800-842-5357).

Deutsche (German):

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 1-800-842-5357).

Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnuv tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyooq uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 1-800-842-5357).

Iloko (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 1-800-842-5357).

Italiano (Italian): Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 1-800-842-5357).

日本語 (Japanese):

この通知には重要な情報が含まれています。 この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 1-800-842-5357)までお電話ください。

한국어 (Korean):

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 1-800-842-5357) 로 전화하십시오.

ລາວ (Lao):

ແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈໍາເປັນຕ້ອງດໍາເນີນການຕາມກໍານົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສະເພາະ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 1-800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។

សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ

ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន

កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជាក់សមត្ថភាពដល់កំណត់ថ្លៃជាក់លាក់នានា

ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។

អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ

និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអសលុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471

(TTY: 1-800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):

ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ

ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਜਵਾਬ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ.

ਜੇਕਰ ਤੁਸੀਂ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ

ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ, ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ

ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ, ਕਾਲ 800-722-1471 (TTY: 1-800-842-5357).

فارسی (Farsi):

این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بی‌مه تان ی کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471

(کاربران TTY تماس با شماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):

To ogłoszenie może zawierać ważne informacje.

To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 1-800-842-5357).

Português (Portuguese):

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 1-800-842-5357).

Română (Romanian):

Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 1-800-842-5357).

Русский (Russian):

Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуются принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 1-800-842-5357).

Fa'asamoa (Samoan):

Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitao olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 1-800-842-5357).

Español (Spanish):

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Primera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 1-800-842-5357).

Tagalog (Tagalog):

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Primera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 1-800-842-5357).

ไทย (Thai):

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ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอเบตประกันสุขภาพของคุณผ่าน Primera Blue Cross
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Український (Ukrainian):

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страховального покриття через Primera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 1-800-842-5357).

Tiếng Việt (Vietnamese):

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Primera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 1-800-842-5357).

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:

- **How Does Selecting A Provider Affect My Benefits?** — how using network providers will cut your costs
- **What Types Of Expenses Am I Responsible For Paying?**
- **What Are My Benefits?** — what's covered and what you need to pay for covered services.
- **Prior Authorization** – Describes the plan's prior authorization and emergency admission notification requirements.
- **What's Not Covered?** — services that are either limited or not covered under this plan
- **Who Is Eligible For Coverage?** – eligibility requirements for this plan
- **How Do I File A Claim?** — step-by-step instructions for claims submissions
- **Complaints And Appeals** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: "You" and "your" refer to members under this plan. "We," "us" and "our" refer to Premera Blue Cross 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 Web site to:

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

TABLE OF CONTENTS

CONTACT US(SEE BACK COVER OF THIS BOOKLET)

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?.....1

Network Providers1

Non-Network Providers1

In-Network Benefits For Non-Network Providers2

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?2

Copayments2

Calendar Year Deductible2

Coinsurance3

Out-Of-Pocket Maximum.....3

WHAT ARE MY BENEFITS?4

What Are My Copays?4

Emergency Room Copay4

Professional Visit Copay.....4

What's My Calendar Year Deductible?5

What's My Coinsurance?5

What's My Out-Of-Pocket Maximum?.....5

Medical Services5

Acupuncture Services.....5

Ambulance Services6

Ambulatory Surgical Center Services6

Blood Products and Services6

Chemical Dependency Treatment.....6

Clinical Trials7

Dental Services.....7

Diagnostic Services8

Diagnostic Mammography.....9

Dialysis9

Emergency Room Services10

Foot Care.....10

Home and Hospice Care10

Hospital Inpatient Care11

Hospital Outpatient Care12

Infusion Therapy.....12

Mastectomy and Breast Reconstruction Services.....13

Medical Equipment and Supplies13

Medical Foods15

Mental Health Care	15
Neurodevelopmental Therapy	16
Newborn Care.....	17
Nutritional Therapy	18
Obstetrical Care.....	19
Preventive Care	20
Professional Visits and Services	22
Psychological and Neuropsychological Testing	23
Rehabilitation Therapy and Chronic Pain Care	24
Skilled Nursing Facility Services.....	25
Spinal and Other Manipulations	25
Surgical Services.....	26
Telehealth Virtual Care Services	26
Temporomandibular Joint (TMJ) Disorders	26
Transplants	27
Urgent Care Centers	29
Special Benefits	30
Prescription Drugs	30
WHAT DO I DO IF I'M OUTSIDE WASHINGTON AND ALASKA?.....	34
Out-Of-Area Care	34
CARE MANAGEMENT	35
Prior Authorization.....	35
How To Ask For Prior Authorization	36
Prior Authorization Penalty	36
Exceptions	36
Prior Authorization For Prescription Drugs.....	37
Prior Authorization For Non-Network Providers	37
Clinical Review	37
Personal Health Support Programs	38
WHAT'S NOT COVERED?	38
WHAT IF I HAVE OTHER COVERAGE?	44
Coordinating Benefits With Other Health Care Plans	44
COB Definitions	45
Primary And Secondary Rules	45
COB's Effect On Benefits	46
Subrogation And Reimbursement.....	47
Uninsured And Underinsured Motorist/Personal Injury Protection Coverage.....	48
WHO IS ELIGIBLE FOR COVERAGE?	48

Subscriber Eligibility	48
Dependent Eligibility.....	48
WHEN DOES COVERAGE BEGIN?	49
Enrollment	49
Dependents Acquired Through Marriage After The Subscriber's Effective Date	49
Natural Newborn Children Born On Or After The Subscriber's Effective Date	49
Adoptive Children Acquired On Or After The Subscriber's Effective Date	49
Foster Children	49
Children Acquired Through Legal Guardianship	50
Children Covered Under Medical Child Support Orders	50
Special Enrollment	50
Involuntary Loss of Other Coverage	50
Subscriber And Dependent Special Enrollment	50
State Medical Assistance and Children's Health Insurance Program	50
Open Enrollment	51
Changes In Coverage	51
Plan Transfers.....	51
WHEN WILL MY COVERAGE END?	51
Events That End Coverage	51
Contract Termination.....	52
HOW DO I CONTINUE COVERAGE?	52
Continued Eligibility For A Disabled Child.....	52
Leave Of Absence.....	53
Family and Medical Leave Act.....	53
Other Leaves of Absence	53
Labor Dispute	54
COBRA.....	54
Qualifying Events And Length Of Coverage.....	54
Conditions Of COBRA Coverage	55
Adding Family Members.....	56
When COBRA Coverage Ends.....	56
If You Have Questions.....	56
3-Month Continuation Of Group Coverage	57
Extended Benefits	57
Continuation Under USERRA	57
Converting To A Non-Group Plan	58
Medicare Supplement Coverage	58
HOW DO I FILE A CLAIM?	58

Timely Filing.....	59
Special Notice About Claims Procedure	59
COMPLAINTS AND APPEALS	60
When You Have Ideas	60
When You Have Questions.....	60
When You Have A Complaint	60
When You Do Not Agree With A Payment Or Benefit Decision	60
When You Have An Appeal	61
Appeals about ongoing care.....	62
When Am I Eligible For External Review?	62
Additional Information About Your Coverage.....	63
OTHER INFORMATION ABOUT THIS PLAN.....	64
Conformity With The Law.....	64
Entire Contract	64
Evidence Of Medical Necessity	64
The Group And You	64
Intentionally False Or Misleading Statements.....	64
Member Cooperation	65
Notice Of Information Use And Disclosure	65
Notice Of Other Coverage.....	65
Notices	65
Right Of Recovery.....	65
Right To And Payment Of Benefits	66
Venue.....	66
Workers' Compensation Insurance.....	66
WHAT ARE MY RIGHTS UNDER ERISA?	66
DEFINITIONS	67

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

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.

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. Its benefits are designed to provide lower out-of-pocket expenses when you receive care from network providers. There are some exceptions, which are explained below.

Network providers are:

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

Network pharmacies are available nationwide.

Network providers provide medical care to members at negotiated fees. These fees are the allowable charges for network providers. When you receive covered services from a network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). Network providers will not charge you more than the allowable charge 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 allowable charges 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 allowable charge for covered services when you use network providers.

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

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

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

Non-Network Providers

Non-network providers are providers that are not in one of the networks shown above. Your bills will be reimbursed at a lower percentage (the out-of-network benefit level).

- Some providers in Washington that are not in the Heritage network do have a contract with us. Even though your bills will be reimbursed at the lower percentage (the non-network benefit level), these providers will not bill you for any amount above the allowable charge for a covered service. The same is true for a provider that is in a different network of the local Host Blue.

- 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. “Non-contracted” providers have the right to charge you more than the allowable charge for a covered service. You may also be required to submit the claim yourself. See "How Do I File A Claim?" for details.

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

Services you receive in a network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are non-network providers. When you receive services from these non-network providers, you may be responsible for amounts over the allowable charge as explained above.

In-Network Benefits For Non-Network Providers

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

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

The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is a network provider. Emergency care furnished by a non-network provider will be reimbursed at the in-network benefit level. As explained above, if you see a non-network provider, you may be responsible for amounts that exceed the allowable charge.

- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Heritage provider who doesn't have admitting privileges at a Heritage hospital.
- Covered 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 a network provider, you can receive benefits for services provided by a non-network provider at the in-network benefit level. However, you must request this before you get the care. See "Prior Authorization" to find out how to do this.

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

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. You'll find the dollar amounts for these expenses and when they apply in the "What Are My Benefits?" section.

COPAYMENTS

Copayments (hereafter referred to as "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.

The copays applicable to the "Medical Services" portion of this plan are located under the "What Are My Copays?" provision in the "What Are My Benefits?" section later in this booklet. Any benefits that are subject to different copays will state those amounts in the benefit.

After your copay, other than Emergency Room services, benefits subject to a copay aren't subject to your deductible and coinsurance.

Please refer to the Emergency Room Services benefit under the "What Are My Benefits?" section for more details.

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible

for any covered service or supply won't exceed the "allowable charge" (please see the "Definitions" section in this booklet).

Individual Deductible

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

Family Deductible

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

The calendar year deductible amounts applicable to the "Medical Services" portion of this plan are located under the "What Are My Benefits?" section.

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 allowable charge
- Charges for excluded services
- The penalty for not asking for prior authorization when the plan requires it. See "Prior Authorization" in the Care Management section 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 network pharmacies stated in the Prescription Drugs benefit

COINSURANCE

"Coinsurance" is a defined percentage of allowable charges 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 allowable charge.

The coinsurance percentage applicable to the "Medical Services" portion of this plan is located under "What's My Coinsurance?" in the "What Are My Benefits?" section. Any benefits that are subject to a different coinsurance percentage will state that percentage in the benefit.

OUT-OF-POCKET MAXIMUM

The "individual out-of-pocket maximum" is the maximum amount, made up of the cost-shares below, that each individual could pay each calendar year for certain covered services and supplies. Please refer to "What's My Out-of-Pocket Maximum?" in the "What Are My Benefits?" section for the amount of any 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 allowable charges for the remainder of that calendar year for covered services that are subject to the maximum.

The out-of-pocket maximum applies to services of both network and non-network providers.

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

- Your coinsurance
 - The calendar year deductible
- Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay any other cost-shares shown in "What Are My Benefits?" until your individual out-of-pocket maximum is reached.
- Copays
 - The difference in cost between a brand name drug and an equivalent generic drug when the plan requires the generic drug to be dispensed in place of the brand name drug.

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

- Charges above the allowable charge
- Charges not covered by the plan
- The penalty for not requesting prior authorization when needed. See "Prior Authorization" in the Care Management section of this booklet.

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

WHAT ARE MY BENEFITS?

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be medically necessary (please see the "Definitions" section in this booklet) and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan.
- It must be furnished by a "provider" (please see the "Definitions" section in this booklet) who's performing services within the scope of his or her license or certification.
- It must meet the standards set in our medical and payment policies. The plan uses policies to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at www.premera.com or by calling Customer Service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions throughout this section and the "What's Not Covered?" section for a complete description of covered services and supplies, limitations and exclusions.

This plan complies with state and federal regulations about coverage for diabetes medical treatment. Please see the Prescription Drugs, Medical Equipment and Supplies, Preventive Care, and Professional Visits and Services benefits.

WHAT ARE MY COPAYS?

Services subject to a copay when received from a network provider are subject to a calendar year deductible and coinsurance when received from non-network providers.

Emergency Room Copay

For each emergency room visit, you pay \$200. Emergency room visits are also subject to any applicable in-network calendar year deductible and coinsurance. The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

Professional Visit Copay

For each office or home visit furnished by a network provider, you pay \$40.

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 network provider on the same day. But only one copay per provider, per day will apply.

In addition to office or home visits, this copay also applies to the following services in an office setting: Biofeedback, rehabilitation therapy, and neurodevelopmental therapy

This copay doesn't apply to the following:

- Services listed under the Home and Hospice Care benefit
- Office visits solely for services that comply with the federal guidelines for preventive services in the Preventive Care benefit.
- Nutritional therapy

WHAT'S MY CALENDAR YEAR DEDUCTIBLE?

Individual Calendar Year Deductible

For each member, this amount is \$6,000 for covered services from network providers.

For covered services from non-network providers, you have a separate calendar year deductible of \$18,000.

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 allowable charges that apply to your individual in-network or non-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.

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

Family Deductible

The maximum calendar year deductible for your family is \$12,000 when covered services are received from network providers.

When covered services are received from non-network providers, you have a separate family deductible of \$36,000.

WHAT'S MY COINSURANCE?

When you see network providers, your coinsurance is 30% of allowable charges.

When you see non-network providers, your coinsurance is 50% of allowable charges.

However, there are a few exceptions to the above coinsurance percentages. Please see the benefits listed below for details:

- The Ambulance Services benefit
- The Emergency Room Services benefit
- The Transplants benefit
- The Diagnostic Services benefit
- The Diagnostic Mammography benefit
- The Prescription Drugs benefit
- The Preventive Care benefit

WHAT'S MY OUT-OF-POCKET MAXIMUM?

Individual Maximum

For each member, this amount is \$6,850 per calendar year, for care from network providers.

There is no out-of-pocket maximum limit for services of non-network providers.

Family Maximum

For each family, this amount is \$13,700 per calendar year, for care from network providers.

MEDICAL SERVICES

Acupuncture Services

Benefits for acupuncture services are subject to your calendar year deductible and coinsurance when you see a network provider.

Please Note: If you see a non-network provider, acupuncture benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition.

Benefits are provided for up to 12 visits per member per calendar year.

Ambulance Services

Benefits for the following services are subject to your in-network calendar year deductible and coinsurance.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered.

Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. Transportation to your home is covered when medically necessary. This benefit only covers the member that requires transportation.

Ambulatory Surgical Center Services

The following services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Blood Products and Services

Benefits are provided for blood and blood derivatives, subject to your calendar year deductible and coinsurance when you use a network provider.

If you use a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services. The Chemical Dependency Treatment benefit does not have its own benefit maximum.

Benefits are subject to the same calendar year deductible, coinsurance or copays, if any, that you would pay for inpatient or outpatient treatment for other covered medical conditions. To find the amounts you are responsible for, please see the first few subsections of this "What Are My Benefits?" section.

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

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

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

The Chemical Dependency Treatment benefit doesn't cover:

- Treatment of alcohol or drug use or abuse that does not meet the definition of "Chemical Dependency" as stated in the "Definitions" section of this booklet
- Voluntary support groups, such as Alanon or Alcoholics Anonymous
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, unless they are medically necessary
- Halfway houses, quarterway houses, recovery houses, and other sober living residences

- Outward bound, wilderness, camping or tall ship programs or activities

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs are the medically necessary care that is normally covered under this plan for a member who is not enrolled in a clinical trial. The trial must be appropriate for your health condition and you must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service you get. For example, benefits for an office visit are covered under the Professional Visits And Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a phase I, II, III or IV clinical trial that is conducted on the prevention, detection or treatment of cancer or other life-threatening disease or conditions. The trial must also be funded or approved by a federal body, such as one of the National Institutes of Health (NIH), a qualified private research entity that meets the standards for NIH support grant eligibility, or by an institutional review board in Washington that has approval by the NIH Office for Protection from Research Risks.

A "clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed solely to collect data for the trial)
- The investigational item, device or service itself
- A service that is clearly not consistent with widely accepted and established standards of care for a particular condition
- Services, supplies or pharmaceuticals that would not be charged to the member, if there were no coverage.
- Services provided in a clinical trial that are fully funded by another source

We encourage you or your provider to call Customer Service before you enroll in a clinical trial. We can help you verify that the clinical trial is a qualified clinical trial.

Dental Services

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

Care For Injuries

Professional Visits

The professional visit copay applies to dentist visits to examine the damage done by a dental injury and recommend treatment. You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Dental Treatment

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If the above services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

When services are related to an injury, benefits are provided for the reparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing

- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
 - Extensive restoration, veneers, crowns or splints
 - Periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury

Please Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date.

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Ambulatory Surgical Center Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

If services and supplies are furnished by a non-network ambulatory surgical center or hospital, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Anesthesiologist Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

If anesthesiologist services are provided by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

General anesthesia and related facility services for dental procedures are covered when medically necessary for 1 of 2 reasons:

- The member is under the age of 19 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center

Please Note: This benefit will not cover the dentist's services unless the services are to treat a dental injury and meet the requirements described above.

Diagnostic Services

When you use a network provider, benefits for the first \$500 of **non-preventive diagnostic services** are covered at 100% of allowable charges, then subject to your calendar year deductible and coinsurance. However, diagnostic surgeries, including scope insertion procedures, that do not meet preventive guidelines, can only be covered under the Surgical Services benefit.

If you see a non-network provider for preventive and non-preventive diagnostic services benefits for the first \$500 of diagnostic services are covered at 100% of allowable charges, then subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Please Note: The first \$500 covered at 100% of allowable charges is shared between the following services:

- Preventive screening services from non-network providers
- Non-preventive diagnostic services from network and non-network providers
- Preventive screening mammography services from non-network providers

- Non-preventive mammography services from network and non-network providers.

Benefits are provided for diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Diagnostic imaging and scans (including x-rays and EKGs)
- Services that are medically necessary to diagnose infertility or that are part of treatment for the cause of infertility.
- Laboratory services
- Pathology tests

In addition to "What's Not Covered?" this Diagnostic Services benefit doesn't cover:

- Allergy testing. See the Professional Visits and Services benefit for coverage of allergy testing.
- Covered inpatient diagnostic services that are furnished and billed by an inpatient facility. These services are only eligible for coverage under the applicable inpatient facility benefit.
- Outpatient diagnostic services that are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services. Benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.
- Mammography. Please see the Diagnostic Mammography benefit.
- Routine screening. Please see the Preventive Care benefit.

Diagnostic Mammography

When you use a network provider, benefits for the first \$500 of **non-preventive mammography** are covered at 100% of allowable charges, then subject to your calendar year deductible and coinsurance. This benefit does not cover routine mammograms. Please see the Preventive Care benefit.

If you see a non-network provider for non-preventive mammography services benefits for the first \$500 of services are covered at 100% of allowable charges, then subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Please Note: The first \$500 covered at 100% of allowable charges is shared between the following services:

- Preventive screening services from non-network providers
- Non-preventive diagnostic services from network and non-network providers
- Preventive screening mammography services from non-network providers
- Non-preventive mammography services from network and non-network providers.

The Diagnostic Mammography benefit covers diagnostic mammography recommended by your physician, advanced registered nurse practitioner or physician's assistant.

Dialysis

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

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

Medicare has a waiting period, generally the first 90 days after dialysis starts. During this waiting period, benefits are subject to the same calendar year deductible and coinsurance, if any, as you would pay for outpatient services for other covered medical conditions. To find the amounts you are responsible for, please see the first few subsections of this "What Are My Benefits?" section.

After Medicare's waiting period, the deductible and coinsurance, if any, for dialysis are waived for network and non-network providers.

Network providers are paid according to their provider contracts. The amount we pay non-network providers for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even if you do not enroll in Medicare.

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. See the "Allowable Charge" definition for more information.

Emergency Room Services

You pay a \$200 copay per visit to the emergency room. Benefits for these services are also subject to your in-network calendar year deductible and coinsurance.

Please Note: The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

This benefit is provided for emergency room services, including related services and supplies, such as surgical dressings and drugs, furnished by and used while in the emergency room. Also covered under this benefit are medically necessary detoxification services. This benefit covers outpatient diagnostic services when they are billed by the emergency room and are received in combination with other hospital or emergency room services.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

You may get care in the emergency room from non-contracted providers. They can bill you for amounts over this plan's allowable charge. See the definition of "allowable charge" to learn about allowable charges for emergency room care.

Foot Care

This benefit covers medically necessary routine foot care.

You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If you see a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Home and Hospice Care

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

Benefits are provided, up to the maximums shown below, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a home health agency and hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work. Also included in this benefit are medical equipment and supplies provided as part of home health care.

Home Health Care

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are provided by network providers.

Please Note: If you see a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit provides up to 130 intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit. Home health care provided as an alternative to inpatient hospitalization is not subject to this limit.

Hospice Care

Benefits for a terminally ill member shall not exceed 6 months of covered hospice care unless the member is facing imminent death, entering remission or meets the requirements below. The initial 6-month period starts on the first day of covered hospice care. Benefits may also be provided for palliative care in cases where the member has a serious or life-threatening condition. Coverage of palliative care is usually approved for 12 months at a time. It can be extended based on the member's specific condition. Coverage includes expanded access to home-based care and care coordination.

Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under Home Health Care. You pay the same share of the allowable charge for in-home hospice care as you do for home health care.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.
- **Inpatient hospice care** up to a maximum of 30 days. 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.

Inpatient hospice care is subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

Prescription drugs and insulin are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If prescription drugs and insulin are furnished and billed by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or 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
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

Hospital Inpatient Care

The following services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network hospital, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets

- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration
- Medically necessary detoxification services

For inpatient hospital chemical dependency treatment, except as stated above for medically necessary detoxification services, please see the Chemical Dependency Treatment benefit.

For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

For benefit information on professional diagnostic services done while at the hospital, see the Diagnostic Services benefit.

This benefit doesn't cover:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary.
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition.

Hospital Outpatient Care

Outpatient Surgery Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Other Outpatient Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network outpatient facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit covers operating rooms, procedure rooms, and recovery rooms. Also covered are services and supplies, such as surgical dressings and drugs, furnished by and used while at the hospital. This benefit covers outpatient diagnostic services only when they are billed by the hospital and received in combination with other outpatient hospital services.

Infusion Therapy

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are furnished by a network provider.

Please Note: When infusion services and supplies are furnished by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit is provided for professional services, supplies, drugs and solutions required for infusion therapy in an outpatient setting, such as your home. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

This benefit doesn't cover over-the-counter drugs, solutions and nutritional supplements.

Mastectomy and Breast Reconstruction Services

Benefits are provided for mastectomy necessary due to disease, illness or injury. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health And Cancer Rights Act of 1998 (WHCRA). For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- All stages of reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

If you would like more information on WHCRA benefits, please call WA Farm Bureau Healthcare Trust or go to www.dol.gov/ebsa/publications/whcra.html.

This benefit is subject to the same cost-shares that apply to other medical and surgical benefits under this plan. Therefore, the following cost-shares apply:

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional and Surgical Services

Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Outpatient Surgical Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Visits

You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Please Note: If mastectomy or breast reconstruction services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Medical Equipment and Supplies

Benefits for the following services are subject to your calendar year deductible and coinsurance when you use a network provider.

If you see a non-network provider, benefits for medical equipment and supplies are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Covered medical equipment, prosthetics and supplies (including sales tax for covered items) include:

Medical and Respiratory Equipment

Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. The plan may also provide benefits for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, the plan will provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical Supplies, Orthotics (Other Than Foot Orthotics), and Orthopedic Appliances

Covered services include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, please see the Prescription Drugs benefit.

Please Note: This benefit does not include medical equipment or supplies provided as part of home health care. See the Home and Hospice Care benefit for coverage information.

Prosthetics

Benefits for external prosthetic devices (including fitting expenses) as stated below, are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

Please Note: This benefit does not include prosthetics prescribed or purchased as part of a mastectomy or breast reconstruction. Please see the Mastectomy and Breast Reconstruction Services benefit for coverage information.

Foot Orthotics and Therapeutic Shoes

Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses.

Medical Vision Hardware

Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

The Medical Equipment and Supplies benefit doesn't cover:

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Eyeglasses or contact lenses for conditions not listed as a covered medical condition, including routine eye care
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.
- Over-the-counter orthotic braces, such as knee braces
- Non-wearable external defibrillators, trusses and ultrasonic nebulizers
- Blood pressure cuffs or monitors (even if prescribed by a physician)

- Compression stockings that do not require a prescription
- Bedwetting alarms

Medical Foods

Benefits for medical foods, as defined below, are subject to your calendar year deductible and coinsurance when you use a network provider.

If you use a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This plan covers medically necessary medical foods used to supplement or replace a member's diet in order to treat inborn errors of metabolism. An example is phenylketonuria (PKU). Coverage includes medically necessary enteral formula prescribed by a physician or other provider to treat eosinophilic gastrointestinal associated disorder or other severe malabsorption disorder. Benefits are provided for all delivery methods.

Medical foods are formulated to be consumed or administered enterally under strict medical supervision. These foods generally provide most of a person's nutrition. Medical foods are designed to treat a specific problem that can be diagnosed by medical tests.

This benefit does not cover other oral nutrition or supplements not used to treat inborn errors of metabolism, even if a physician prescribes them. This includes specialized infant formulas and lactose-free foods.

Mental Health Care

Benefits for mental health services to manage or lessen the effects of a psychiatric condition are provided as stated below. The Mental Health Care benefit does not have its own benefit maximum.

Benefits are subject to the same calendar year deductible, coinsurance or copays, if any, as you would pay for inpatient services and outpatient visits for other covered medical conditions. To find the amounts you are responsible for, please see the first few subsections of this "What Are My Benefits?" section.

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

Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all ABA services for a member may be managed by a BCBA or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques. ABA therapy must be provided by:

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

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

- Hospital
- Washington state-licensed community mental health agency
- Licensed physician (M.D. or D.O.)
- Licensed psychologist (Ph.D.)
- A state hospital operated and maintained by the state of Washington for the care of the mentally ill
- Any other provider listed under the definition of "provider" (please see the "Definitions" section in this booklet) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license.

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

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

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

For prescription drug benefit information, please see the Prescription Drugs benefit.

The Mental Health Care benefit doesn't cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- 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

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 Benefits for inpatient facility and professional care are provided up to 30 days per member each calendar year. 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.

Inpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for inpatient care are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Outpatient Care Benefits for outpatient care 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

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, up to a maximum benefit of 25 visits per member each calendar year.

Outpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Services

You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for outpatient care are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

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

This benefit doesn't cover:

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

Newborn Care

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

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

Plan benefits and provisions will apply, subject to the child's own applicable copay, calendar year deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If the newborn is admitted to a non-network medical facility, benefits for inpatient facility services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother. In any case, plans and issuers also may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

Professional Care

Benefits for services received in a provider's office are subject to the terms of the Professional Visit 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

Inpatient Professional Care

Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Outpatient Professional Visits

You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

If you use a non-network provider, benefits for professional services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

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

Nutritional Therapy

Benefits for nutritional therapy are not subject to any copay, calendar year deductible, or coinsurance when you use a network provider.

If you see a non-network provider, nutritional therapy benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for outpatient nutritional therapy services that are medically necessary to manage your covered condition, illness or injury. Examples of covered conditions are diabetes and eating disorders. These services aren't subject to a calendar year benefit limit.

Obstetrical Care

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

The Obstetrical Care benefit includes coverage for abortion.

Facility Care

Inpatient Hospital Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Birthing Center and Short-Stay Hospital Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

If you receive inpatient or outpatient care in a non-network medical facility, facility care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother. In any case, plans and issuers also may not, under Federal law, require that a provider get authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

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

Professional Care

Benefits for the following obstetrical care services are subject to your calendar year deductible and coinsurance when provided by a network provider.

If you see a non-network provider, the following professional care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. Please see the Surgical Services benefit for details on surgery coverage.

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

Preventive Care

This plan pays for preventive care from network providers. Below is a summary of your costs for preventive care.

Preventive Care	Network Providers	Non-Network Providers
Preventive Exams <ul style="list-style-type: none"> 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 	No charge	\$18,000 deductible and 50% coinsurance
Immunizations <ul style="list-style-type: none"> Shots in a provider's office for dependent children to age 18 Shots in a provider's office for members over 18 	No charge	No charge
<ul style="list-style-type: none"> Flu shots, flu mist, whooping cough and other seasonal shots at a pharmacy or other community center Shots needed for foreign travel at the county health department or a travel clinic 	No charge	No charge
Screening Tests Routine lab tests and imaging, such as: <ul style="list-style-type: none"> Mammograms X-rays and EKG tests Pap smears Prostate-specific antigen tests BRCA genetic tests for women at risk for certain breast cancers. 	No charge	Benefits for the first \$500 of preventive diagnostic services are covered at 100% of allowable charges, then benefits are subject to your \$18,000 deductible and 50% coinsurance
Colon Cancer Screening For members who are 50 or older or who are under age 50 and at high risk for colon cancer. Includes: <ul style="list-style-type: none"> Colonoscopy, sigmoidoscopy and fecal occult blood tests. The plan also covers a consultation before the colonoscopy and anesthesia your doctor thinks is medically necessary. If polyps are found during a screening procedure, removing them and lab tests on them are also covered as preventive. 	No charge	\$18,000 deductible and 50% coinsurance
Pregnant Women's Care <ul style="list-style-type: none"> Breastfeeding support and counseling Purchase of standard electric breast pumps Rental of hospital-grade breast pumps if medically necessary Screening for postpartum depression 	No charge	\$18,000 deductible and 50% coinsurance

Birth Control <ul style="list-style-type: none"> • Birth control devices, shots and implants • Emergency contraceptives ("plan B") • Tubal ligation 	No charge	\$18,000 deductible and 50% coinsurance
Diabetes Screening	No charge	\$18,000 deductible and 50% coinsurance
Diabetes Health Education	No charge	\$18,000 deductible and 50% coinsurance
Health Education and Training* Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease and asthma. Also covers childbirth and training for new parents. The program or class must have our approval.	No charge	Not Covered
Nicotine Habit-Breaking Programs Programs to stop smoking, chewing tobacco or taking snuff.	No charge	\$18,000 deductible and 50% coinsurance
Nutritional Counseling One-on-one office visits to discuss eating habits and help you manage weight. This includes screening and counseling for 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	No charge	\$18,000 deductible and 50% coinsurance
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	No charge	\$18,000 deductible and 50% coinsurance

About Preventive Care

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

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

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

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

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

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

For example:

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

Please Note: The first \$500 covered at 100% of allowable charges is shared between the following services:

- Preventive screening services from non-network providers
- Non-preventive diagnostic services from network and non-network providers
- Preventive screening mammography services from non-network providers
- Non-preventive mammography services from network and non-network providers.

The Preventive Care benefit does not cover:

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

Professional Visits and Services**Outpatient Professional Exams and Visits**

You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside of an office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If you see a non-network provider, professional benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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 and treatment for nicotine dependency
- Consultations with a pharmacist

Electronic Visits

This benefit will cover electronic visits (e-visits) when all the requirements below are met. You pay the same cost-shares for e-visits as you do for in-person visits to the doctor's office. 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.

Therapeutic Injections And Allergy Tests

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

If therapeutic injections, allergy injections and allergy testing are furnished by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are available for the following:

- Therapeutic injections, including allergy injections
- Allergy testing

Your calendar year deductible and coinsurance, if any, may apply to other services you get during a visit. This includes services such as x-rays, lab work, facility fees and office surgeries.

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

For professional diagnostic services benefit information, please see the Diagnostic Services benefit.

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

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

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

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

The Professional Visits and Services benefit doesn't cover:

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

Psychological and Neuropsychological Testing

The following services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If you see a non-network provider, benefits for psychological and neuropsychological testing are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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 and Chronic Pain Care benefit.

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

Rehabilitation Therapy and Chronic Pain Care

Rehabilitation Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Please see the Neurodevelopmental Therapy benefit earlier in this section for coverage of disorders caused by neurological congenital anomalies.

Inpatient Care Benefits for inpatient facility and professional care are available up to 30 days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility that meets our clinical standards, and will only be covered when services can't be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. 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. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

Inpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

If services and supplies are furnished by a non-network provider or medical facility, rehabilitation inpatient care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Outpatient Care Benefits for outpatient care are subject to all of the following provisions:

- You 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.

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 25 visits per member each calendar year. However, the visit limit does not apply when the outpatient services are to treat cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases.

Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

Outpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Services

You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When rehabilitation therapy isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance.

If services and supplies are furnished by a non-network provider or medical facility, rehabilitation outpatient care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Massage therapy provided by a licensed massage therapist must be prescribed by a physician.

Chronic Pain Care

These services must also be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits. All benefit maximums apply. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

The Rehabilitation Therapy and Chronic Pain Care 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
- 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

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

Skilled Nursing Facility Services

Benefits for the following services are subject to your calendar year deductible and coinsurance when you use a network facility.

If you're admitted to a non-network medical facility, benefits for facility services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 90 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility.

This benefit doesn't cover:

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

Spinal and Other Manipulations

Benefits for spinal and other manipulations are subject to your calendar year deductible and coinsurance when you see a network provider.

Please Note: If you see a non-network provider, benefits for spinal and other manipulations are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition. Benefits are limited to 12 visits per member per calendar year.

Non-manipulation services (including diagnostic imaging) are covered as any other medical service.

Available benefits for covered massage and physical therapy services are provided under the Rehabilitation Therapy and Chronic Pain Care and Neurodevelopmental Therapy benefits.

Surgical Services

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

If you use a non-network provider, benefits for surgical services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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. Also covered is sexual reassignment surgery if medically necessary and not for cosmetic purposes.
- 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.
- Vasectomy

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

Telehealth Virtual Care Services

Your plan covers access to care via online and telephonic methods when medically appropriate.

Benefits for telehealth are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.

Coverage for psychiatric conditions is medically appropriate for crisis and emergency evaluations or when the member is temporarily confined to bed for medical reasons only.

Your provider may provide these services or you may use our preferred telehealth provider. See the back cover for contact information for the preferred telehealth provider.

Temporomandibular Joint (TMJ) Disorders

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional and Surgical Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Outpatient Surgical Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Visits

You pay a \$40 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you see a network provider.

If services and supplies are furnished by a non-network provider or medical facility, benefits for temporomandibular joint (TMJ) disorders are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. Treatment of TMJ disorders is not covered under other benefits of this plan.

This benefit includes coverage for inpatient and outpatient facility and professional care, including professional visits.

Medical and dental services and supplies 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 or dental practice
- Not experimental or investigational, according to the criteria stated under "Definitions," or primarily for cosmetic purposes

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 network providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Inpatient Facility Services

Benefits for services in a network facility or an approved transplant center are subject to your in-network calendar year deductible and coinsurance.

Inpatient Professional and Surgical Services

Benefits for a network provider or an approved transplant provider are subject to your in-network calendar year deductible and coinsurance.

Outpatient Surgical Facility Services

Benefits for a network facility or an approved transplant center are subject to your in-network calendar year deductible and coinsurance.

Outpatient Professional Visits

You pay a \$40 copay per visit in an office setting to a network provider or an approved transplant provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When a professional visit isn't provided in an office setting, benefits are subject to your in-network calendar year deductible and coinsurance.

Other Outpatient Professional Services

Benefits for a network provider or an approved transplant provider are subject to your in-network calendar year deductible and coinsurance.

Travel and Lodging

The travel and lodging benefits are subject to your in-network calendar year deductible, but aren't subject to your in-network coinsurance. Benefits are provided up to the benefit limit of \$7,500 per transplant.

Covered Transplants

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

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

Please Note: For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (please see the Surgical Services 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 regimen 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

If you are getting a transplant, this benefit covers costs for your travel and lodging. The plan will not pay more than \$7,500 for travel and lodging per transplant. You must live more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require you to stay closer to the transplant center. The plan covers travel and lodging up to the limits set by the IRS for the date you had the expense.

- **Travel:** Travel is covered only between your home and the approved transplant center. Round trip costs for air, train or bus travel (coach class only) are covered. If you travel by car, the plan covers mileage, parking and toll costs.

- **Lodging:** Hotel or motel stays away from home.
- **Companions:** Travel and lodging for 1 companion is covered if the companion has to come with the member due to medical necessity or safety. For a child under age 19, the plan will cover one companion automatically. Costs for a second companion are only covered when medically necessary.
- **Limits:** The plan covers travel and lodging costs up 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.
- **Costs Not Covered**
 - Meals
 - Lodging in any location other than a hotel or motel
 - Alcohol or tobacco
 - Car rental
 - Entertainment, such as movies, visits to museums, or mileage for sightseeing
 - Costs for people other than you and your covered companion(s)
 - Personal care items, such as shampoo or a toothbrush
 - Tourist items, such as T-shirts, sweatshirts, or toys
 - Phone calls

The Transplants benefit doesn't cover:

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

Urgent Care Centers

This plan covers care you get in an urgent care center. Urgent care centers have extended hours and are open to the public. You can go to an urgent care center for an illness or injury that needs treatment right away. Examples are minor sprains, cuts and ear, nose and throat infections. Covered services include the doctor's services.

- If the urgent care center is **not** a part of a hospital or is **not** attached to a hospital:
 You pay a \$40 copay per visit when you use a network center. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.
 You may have to pay a separate copay or your deductible and coinsurance for other services you get during a visit to the urgent care center. This includes things like x-rays, lab work, shots and office surgeries. See those covered services for details.
 If you use a non-network urgent care center, you pay your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.
- If the urgent care center **is** part of a hospital or is located in or attached to hospital, you pay a \$200 copay per visit. Benefits for these services are also subject to your in-network calendar year deductible and coinsurance. You may also have to pay your in-network calendar year deductible and coinsurance if the center charges facility fees.

SPECIAL BENEFITS

Prescription Drugs

You Pay (Per Prescription or Refill)

In no case will you pay more than the cost of the drug or supply.

Covered Drug	Network Retail Pharmacy	Non-Network Retail Pharmacy
Generic drugs	\$10 copay	\$10 copay plus amounts over the allowable charge
Preferred brand name Drugs	\$50 copay	\$50 copay plus amounts over the allowable charge
Non-preferred brand Name drugs	\$80 copay	\$80 copay plus amounts over the allowable charge
	Network Mail-Order Pharmacy	Non-Network Mail-Order Pharmacy
Generic drugs	\$30 copay	Not covered
Preferred brand name drugs	\$150 copay	Not covered
Non-preferred brand name drugs	\$240 copay	Not covered

Specialty Drugs	Network Specialty Pharmacy	Non-Network Specialty Pharmacy
Specialty drugs	Same as retail	Not covered

Exceptions	Network Retail or Mail-Order Pharmacy	Non-Network Retail Pharmacy
• Prescription birth control devices	No charge	Same as non-network retail
• Generic emergency birth control drugs	No charge	\$10 copay plus amounts over the allowable charge
• Single-source brand name birth control drugs	No charge	\$50 copay plus amounts over the allowable charge
• Needles and syringes purchased with insulin	No charge	No charge
• Certain prescription drugs and generic over-the-counter drugs to break a nicotine habit	No charge	Same as non-network retail
• Drugs on the Affordable Care Act's preventive drug list	No charge	Same as non-network retail

• Oral chemotherapy	No charge	No deductible, copay or coinsurance
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To find a network pharmacy, or if you have questions, please call us at the number on the back of this booklet. You can also call the toll-free Pharmacy Locator Line. This number is on the back of your plan ID card.

GETTING PRESCRIPTIONS FILLED

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

Pharmacy	Supply Limit	Instructions
Network Retail or Network Specialty Pharmacies	30 days*	Pay the cost-share in the table above at the pharmacy
Non-Network Retail Pharmacies	30 days*	<ul style="list-style-type: none"> • 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.
Network Mail-Order Pharmacy	90 days	<ul style="list-style-type: none"> • Allow 2 weeks for your prescription to be filled. • Ask your doctor to prescribe up to a 90-day supply of the drug you need. • Send your prescriptions and a pharmacy mail-order form to the mail-order pharmacy. You can download the form from our website or call us for a copy. Our website and phone numbers are on the back cover of this booklet.

**The plan can cover more than the supply limit above if the drug maker’s packaging does not let the exact amount above be dispensed. If you have copays for drugs from a retail or specialty pharmacy, you must pay a second copay for a 30-day to 60-day supply and a third copay for a 60-day to 90 day supply.*

What’s Covered

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

Diabetic Drugs

Birth Control

- Prescription birth control drugs and devices for men and women
- Over the counter female birth control devices and supplies that your doctor prescribes

Shots You Give Yourself

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

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

Oral Chemotherapy This benefit covers drugs you can take by mouth that can be used to kill cancer cells or slow their growth. This benefit only covers the drugs that you get from a pharmacy. You pay no cost-share when the drug is medically necessary.

Glucagon and Allergy Emergency Kits

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

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

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

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

Exclusions

This benefit does not cover:

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

Drug Discount Programs

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

In addition, the allowable charge that your payment for drugs is based on may be higher than the price Premera Blue Cross pays its drug 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 allowable charge. The allowable charge is not adjusted to reflect discounts received as part of Drug Discount Programs.

Your Right To Safe And Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service. The phone numbers are shown on the back cover of this booklet.

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

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?

Your coverage for drugs is not restricted to drugs on a specific list. This plan's prescription drug benefit makes use of our list of drugs, sometimes called a "formulary." We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the list.

It's important to note that this plan provides benefits for non-preferred brand name drugs, but at a higher cost to you. However, this plan doesn't cover certain categories of drugs. These are listed under "Exclusions" earlier in this benefit.

- **Generic Substitution** This plan requires the use of appropriate "generic drugs" (as defined below). When available, a generic drug will be dispensed in place of a brand name drug. If there is no generic equivalent, the applicable brand name cost-share will apply. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you'll have to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name drug cost-share. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

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

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

- **Right to a Review** If you cannot tolerate the generic equivalent drug, or the prescriber determines that it is not effective in treating your condition, the prescriber can request a medical necessity review. If approved, you'll only have to pay the applicable brand-name cost-share.

In no case will your out-of-pocket expense exceed the cost of the drug.

Certain drugs need prior authorization. As part of this review, some prescriptions may require more medical information from the prescribing provider or substitution of equivalent medication. Please see "Prior Authorization" in the Care Management section of your booklet for more detail.

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. This committee includes medical practitioners and pharmacists from the community. They review current medical studies and pharmaceutical information to decide which drugs to include on the pharmacy drug list.

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

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

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

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

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

You will find the amounts you pay for covered drugs in the "What You Pay" table above.

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 network pharmacies. The majority of retail pharmacies in Washington are part of our pharmacy network. Your

benefit covers prescription drugs dispensed from a non-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 network mail order pharmacy.

You can find a 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 "What You Pay" table above for more information.

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

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the mail-order pharmacy benefit are described in the "Dispensing Limit" provision above.

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

- The number of units and days' supply dispensed on the last refill
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill

Exceptions to the limit may be allowed as required by law. For example, a pharmacist can authorize an early refill of a prescription for eye drops and eye ointment in some cases. A different supply with pro-rated cost-shares can also be allowed so that a new drug can be refilled at the same time as drugs that you are already taking. We 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.

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.

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 outside our service area. These arrangements are called "Inter-Plan Arrangements." Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

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

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

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

BlueCard Program

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

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

Often, the allowable charge 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 allowable charge 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 allowable charge 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 allowable charge for the claim.

Non-Contracted Providers

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

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.

BlueCard Worldwide® Program

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 BlueCard Worldwide. BlueCard Worldwide is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide 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 outside our service area, go to www.premera.com or call 1-800-810-BLUE (2583). You can also get BlueCard Worldwide 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

Your coverage for some services depends on whether the service is approved through the prior authorization process before you receive it.

A planned service is reviewed to make sure it is medically necessary and eligible for coverage under this plan. We will let you know in writing if the service is authorized. We will also let you know if the services are not authorized and the reasons why. If you disagree with the decision, you can request an appeal. See "When You Have An Appeal" in your booklet or call us.

There are three situations where prior authorization is required:

- Before you receive certain medical services or prescription drugs
- Before you schedule a planned admission to certain inpatient facilities
- When you want to receive the in-network benefit level for services you receive from a non-network provider.

How To Ask For Prior Authorization

The plan has a specific list of services that must have prior authorization with any provider. The list is on our Web site at www.premera.com. Before you receive services, we suggest that you review this list.

Services From Network Providers: It is your network provider's responsibility to get prior authorization. Your network provider can call us at the number listed on your ID card to request a prior authorization.

Services From Non-Network Providers: It is your responsibility to get prior authorization for any services that are on the prior authorization list when you see a non-network provider. You or your provider can call us at the number listed on your ID card to request a prior authorization. However, it is a good idea to call us to make sure the request was approved.

We will respond to a request for prior authorization within 5 calendar days of receipt of all information necessary to make a decision. If your situation is clinically urgent (meaning that your life or health would be put in serious jeopardy if you did not receive treatment right away), you may request an expedited review. Expedited reviews are responded to as soon as possible, but no later than 48 hours after we get all the information necessary to make a decision. We will provide our decision in writing.

Our prior authorizations will be valid for 30 calendar days. This 30-day period is subject to your continued coverage under the plan. If you don't receive the service, drug or item within that time, you will have to ask us for another prior authorization.

Prior Authorization Penalty

For Services From Network Providers

Network providers will get a prior authorization for you. You should verify with your provider that a prior authorization request has been approved in writing before you receive services.

For Services From Non-Network Providers

It is your responsibility to get prior authorization for any services that are on the prior authorization list when you see a non-network provider. **If you do not get prior authorization, but the service is covered by the plan, you will have to pay a penalty. The penalty is 50 percent of the allowable charge. The maximum penalty is \$1,500 per occurrence.** You pay this penalty plus any cost-share that your plan requires for the covered services.

The prior authorization penalty does not count toward this plan's deductible or out-of-pocket maximum, if any.

Exceptions

The services below do not need prior authorization. Instead, you must tell us as soon as reasonably possible after you receive them:

- Emergency hospital admissions, including admissions for drug or alcohol detoxification. If you are admitted to a non-network hospital due to a medical emergency, those services are always covered under your in-network cost-share. The plan will continue to cover those services until you are medically stable and can safely transfer to a network hospital. If you choose to remain at the non-network hospital after you are stable to transfer, coverage will revert to the out-of-network benefit. The plan will provide benefits based on the allowable charge. If the hospital is non-network, you may be billed for charges over the allowable charge.
- Childbirth admission to a hospital, or admissions for newborns who need medical care at birth. Admissions to a non-network hospital will be covered at the non-network cost-share unless the admission was a medical emergency.

- You may have a second plan that also asks you to get prior authorization for the same service. In that case, this plan will not require prior authorization for that service when two things are true:
 - Your other plan is primary to this plan. See "Coordinating Benefits With Other Health Care Plans" to find out how to tell which plan is primary.
 - You complied with the other plan's prior authorization process.

Prior Authorization For Prescription Drugs

Certain prescription drugs you receive through a pharmacy must have prior authorization before you get them at a pharmacy, in order for the plan to provide benefits. Your provider can ask for a prior authorization by faxing a prior authorization form to us. This form is in the pharmacy section of our Web site at www.premera.com. You will also find the specific list of prescription drugs requiring prior authorization on our Web site. If your prescription drug is on this list, and you do not get prior authorization, when you go to the pharmacy to fill your prescription, your pharmacy will tell you that it needs to be prior authorized. You or your pharmacy should call your provider to let them know. Your provider can fax us a prior authorization form for review.

If Premera Blue Cross or the prescriber cannot be reached at the time a network pharmacy asks for a prior authorization, the plan may cover a small supply of the drug to allow more time for the prior authorization. The cost-shares shown in the Prescription Drug benefit will apply. Network pharmacies will take care of this for you. If an advance 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 allowable charge. See "How Do I File A Claim?" for details.

Benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- You may need to get a prescription drug from an appropriate medical specialist
- You may have to try a generic drug or a specified brand name drug first

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

Prior Authorization For Non-Network Providers

This plan provides benefits for non-emergency services from non-network providers at a lower benefit level. You may receive benefits for these services at the in-network cost-share if the services are medically necessary and only available from a non-network provider. You or your provider may request a prior authorization for the in-network benefit before you see the non-network provider.

The prior authorization request must include the following:

- A statement that the non-network provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from a network provider
- Any necessary medical records supporting the request.

If the request is approved, you pay the in-network cost-share for covered services.

If the request is denied but the plan does cover the services, you will have to pay the non-network cost-share.

Whether or not your request is approved, you will also have to pay any amounts over the plan's allowable charge for covered services.

CLINICAL REVIEW

Premera Blue Cross has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. Our medical policies are on our Web site. You or your provider may review them at www.premera.com. 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.

WHAT'S NOT COVERED?

This section of your booklet explains circumstances in which all the benefits of this plan are either limited or no benefits are provided. Benefits can also be affected by our "Care Management" provisions and your eligibility. In addition, some benefits have their own specific limitations.

In addition to the specific limitations stated elsewhere in this plan, we won't provide benefits for the following:

Assisted Reproduction

This plan does not cover:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures.
- 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
- Undoing sterilization surgery
- Complications of assisted reproduction services

Please see the Diagnostic Services and Surgical Services benefits for coverage of medical services to diagnose and correct medical conditions that may cause infertility, including tests to monitor the outcomes.

Benefits From Other Sources

This plan does not cover services that are covered by such types of insurance 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 home owners' coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits That Have Been Exhausted

Amounts that exceed the allowable charge or maximum benefit for a covered service.

Biofeedback

Biofeedback that is deemed experimental or investigational treatment for the condition (see "Definitions"). Examples of what is not covered are EEG biofeedback and neurofeedback.

Caffeine Or Nicotine Dependency

Treatment of caffeine dependency; treatment of nicotine dependency except as stated under the Preventive Care, Professional Visits and Services and Prescription Drugs benefits.

Charges For Records Or Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review.

Chemical Dependency Coverage Exceptions

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous

Cosmetic Services

The plan does not cover services, drugs, or supplies for cosmetic purposes, including any direct or indirect complications and aftereffects. Examples of what is not covered are:

- Reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an injury, providing such repair is started within 12 months of the date of the injury. Please see the Surgical Services benefit.
- Repair of a dependent child's congenital anomaly. Please see the Surgical Services benefit.
- Reconstructive breast surgery in connection with a mastectomy as specified under the Mastectomy and Breast Reconstruction Services benefit
- Correction of functional disorders upon our review and approval. This does not include removal of excess skin and or fat related to weight loss surgery or the use of drugs for weight loss. Please see the Surgical Services benefit.
- Genital or breast surgery that meets medical necessity criteria or is medically necessary for the treatment of gender dysphoria diagnoses.

Counseling, Educational Or Training Services

- Counseling, education or training services, except as stated under the Chemical Dependency Treatment, Nutritional Therapy, Professional Visits and Services and Mental Health Care benefits or for services that meet the standards for preventive services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy
- 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 are otherwise should be provided by school staff. This does not apply to training that is directed at the member's significant behavioral difficulties during schoolwork. Please see the Mental Health Care benefit.

Court-Ordered Services

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except as deemed medically necessary.

Custodial Care

Custodial care, except when provided for hospice care (please see the Home and Hospice Care benefit).

Dental Care

Dental services or supplies, except as specified under the Dental Services or Temporomandibular Joint (TMJ) Disorders benefits. (Please see the "Medical Services" section under "What Are My Benefits?" earlier in this booklet.)

Donor Breast Milk

Drugs And Food Supplements

Over-the-counter drugs, solutions, supplies, food and nutritional supplements other than those covered under the Medical Foods benefit; over-the-counter contraceptive drugs (except as required by law), supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that don't require a prescription, except as required by law. Please see the Prescription Drugs benefit for details.

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental Or Investigational Services

Any service or supply that Premera Blue Cross determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of "experimental/investigational services" (please see the "Definitions" section in this booklet).

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the "Complaints And Appeals" section in this booklet for an explanation of the appeals process.

Family Members Or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

Governmental Medical Facilities

Services and supplies furnished by a governmental medical facility, except when:

- Your request for a benefit level exception for non-emergent care to the facility is approved. (Please see the "Prior Authorization" subsection in this booklet)
- You're receiving care for a "medical emergency" (please see the "Definitions" section in this booklet)
- We must provide available benefits for covered services as required by law or regulation

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

Hearing Exams And Testing

Routine hearing exams and testing, including hearing exams for the purpose of prescribing or fitting a hearing aid, are only covered as described under the Routine Hearing Exams benefit, if this plan includes one. When included, a description of the Routine Hearing Exams benefit will appear in the "Special Benefits" section earlier in the booklet.

Hearing Hardware

Hearing aids and devices used to improve hearing sharpness are only covered as described under the Hearing Hardware benefit, if this plan includes one. When included, a description of the Hearing Hardware benefit will appear in the "Special Benefits" section earlier in the booklet.

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Specialty Pharmacy Program (please see the Prescription Drugs benefit) and are not covered to treat idiopathic short stature without growth hormone deficiency.

Illegal Acts and Terrorism

This plan does not cover illness or injuries resulting from a member's commission of:

- A felony (does not apply to a victim of domestic violence)
- An act of terrorism
- An act of riot or revolt

Laser Therapy

Low-level laser therapy

Light Therapy For Vitiligo

Medical Equipment And Supplies

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.
- Over-the-counter orthotic braces, such as knee braces
- Non-wearable external defibrillators, trusses and ultrasonic nebulizers
- Blood pressure cuffs or monitors (even if prescribed by a physician)
- Compression stockings that do not require a prescription
- Bedwetting alarms
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications, except as specified in the Prescription Drugs benefit.

Military Service and War

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

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

No Charge Or You Don't Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, except as required by law in the case of federally qualified health center services

Non-Treatment Facilities, Institutions Or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes, camps and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations. Please see the applicable medical benefit, the Mental Health Care benefit, or the Chemical Dependency Treatment benefit for details.

Not Covered

- Services or supplies ordered when this plan isn't in effect, or when the person isn't covered under this plan, except as stated under specific benefits and under "Extended Benefits"

- Services or supplies provided to someone other than the ill or injured member, other than outpatient health education services covered under the Preventive Care benefit. This includes training or educational services to another provider.
- Services and supplies that aren't listed as covered under this plan
- Services and supplies directly related to any condition, or related to any other service or supply that isn't covered under this plan

Not In The Written Plan Of Care

Services, supplies or providers not in the written plan of care or treatment plan, or not named as covered in the Home and Hospice Benefit, Neurodevelopmental Therapy and Rehabilitation Therapy and Chronic Pain Care benefits.

Not Medically Necessary

- Services or supplies that aren't medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care.
- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition

Online or Telephone Consultations And Telehealth Services

Benefits are not provided for electronic, telephone, online or Internet medical consultations or evaluations except as provided under the Telehealth Virtual Care Services benefit and the electronic visits covered under the Professional Visits and Services benefit.

Orthodontia Services

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

Orthognathic Surgery (Jaw Augmentation Or Reduction)

Procedures to lengthen or shorten the jaw (orthognathic surgery) are only covered as described under the Orthognathic Surgery benefit, if this plan includes one. When included, a description of the Orthognathic Surgery benefit will appear in the "Special Benefits" section earlier in the booklet. This exclusion applies regardless of the origin of the condition that makes the procedure necessary. The only exception to this exclusion is for repair of a dependent child's congenital anomaly. Please see the Surgical Services benefit.

Outside The Scope Of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider's license or certification. Services or supplies that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received, except as allowed for applied behavior analysis providers by the Mental Health Care benefit.

Personal Comfort Or Convenience Items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges, babysitting
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home and Hospice Care benefit); and transportation services
- Dietary assistance, such as "Meals on Wheels"
- Charges for provider travel time
- Transporting a member in place of a parent or other family member, or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.
- Arrangements in which the provider lives with the member.

Private Duty Nursing Services

Private duty nursing.

Rehabilitation Services

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.

Routine Or Preventive Care

- Impression casting for foot prosthetics or appliances and prescriptions thereof. However, foot-support supplies, devices and shoes are covered as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related disability or medical disability

Serious Adverse Events and Never Events

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

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

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

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

Sexual Dysfunction

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

Skilled Nursing Facility Coverage Exceptions

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency

Transplant Coverage Exceptions

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under the Transplants benefit
- Services or 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 not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (please see the "Definitions" section in this booklet)

Vision Exams

Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware are only covered as described under the Vision Exams benefit, if this plan includes one. When included, a description of the Vision Exams benefit will appear in the "Special Benefits" section earlier in this booklet.

Vision Hardware

Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies are only covered as described in the Vision Hardware benefit, if this plan includes one, and the Medical Equipment and Supplies benefit. When included, a description of the Vision Hardware benefit will appear in the "Special Benefits" section earlier in this booklet.

This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

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

Voluntary Support Groups

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous, peer-mediated groups or interventions

Weight Loss Surgery or Drugs

Surgery or drugs for weight loss or to manage weight, even if you also have an illness or injury that might be helped by weight loss. Also not covered are any direct or indirect complications, follow-up services, and aftereffects thereof. (An example of an aftereffect that would not be covered is removal of excess skin or fat that came about because of the surgery or drugs.) This exclusion applies to all weight loss surgeries, no matter where you have them. It also applies to all drugs and supplements for weight loss.

Work-Related Conditions

Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

- Occupational coverage required of, or voluntarily obtained by, the employer
- State or federal workers' compensation acts
- Any legislative act providing compensation for work-related illness or injury

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

WHAT IF I HAVE OTHER COVERAGE?

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

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

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

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

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

COB Definitions

For the purposes of COB:

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

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

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

Primary And Secondary Rules

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

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

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

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

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

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.

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

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

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

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

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

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

COB's Effect On Benefits

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

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

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

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

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the

consent of anyone to do this. State regulations require each of your other plans and each person claiming benefits under this plan to give us any facts we need for COB. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

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

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

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

SUBROGATION AND REIMBURSEMENT

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

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage. We will use our expertise and judgment to reasonably construe the terms of this booklet as they apply to your eligibility for benefits. 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 determination.

Please note that you do not have to be a citizen of or live in the United States if you are otherwise eligible for coverage.

SUBSCRIBER ELIGIBILITY

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

- The employee must be a regular and active employee of the Participating Employer who is paid on a regular basis through the Participating Employer's payroll system, and reported by the Participating Employer for Social Security purposes. The employee must also meet 2 other requirements. The employee must:
 - Regularly work the minimum hours required by the Participating Employer
 - Complete the probationary period, if any, required by the Participating Employer

Employees Performing Employment Services In Hawaii

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

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated. ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction.)

However, if the spouse is an owner, partner, or corporate officer of the Participating Employer who meets the requirements in "Subscriber Eligibility" earlier in this section, the spouse can only enroll as a subscriber.

- The domestic partner of the subscriber. Domestic partnerships that are **not** documented in a state domestic partnership registry must meet all requirements as stated in the signed "Affidavit of Domestic Partnership."

All rights, benefits and obligations afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."

- An eligible dependent child who is under 26 years of age

An eligible child is one of the following:

- A natural offspring of either or both the subscriber or spouse
- A legally adopted child of either or both the subscriber or spouse
- A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child

- A legally placed ward or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

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

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

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

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

Dependents Acquired Through Marriage After The Subscriber's Effective Date

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

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

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To extend the child's coverage beyond the 3-week period, the subscriber should follow the steps below. If the mother isn't eligible for obstetrical care benefits, but the child qualifies as an eligible dependent, the subscriber should follow the steps below to enroll the child from birth.

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

Adoptive Children Acquired On Or After The Subscriber's Effective Date

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

Foster Children

To enroll a new foster child, we must get any payment needed, a filled out enrollment form, and a copy of the child's foster papers. We must get these items no more than 60 days after the date the subscriber became the child's foster parent. When we get these items on time, the plan will cover the child as of the date the subscriber

became the child's foster parent. If we do not get the items on time, the child must wait for the Group's next open enrollment period to be enrolled.

Children Acquired Through Legal Guardianship

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

Children Covered Under Medical Child Support Orders

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

SPECIAL ENROLLMENT

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

Involuntary Loss of Other Coverage

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

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

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

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

Subscriber And Dependent Special Enrollment

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

State Medical Assistance and Children's Health Insurance Program

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

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

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

OPEN ENROLLMENT

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

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

CHANGES IN COVERAGE

No rights are vested under this plan. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

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

PLAN TRANSFERS

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

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

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

When you transfer from another Premera Blue Cross plan offered by the Group, and there's no lapse in your coverage, the benefit maximums of this plan will be reduced to the extent they were satisfied under the prior plan:

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when:
 - The Group contract is terminated
 - The next monthly subscription charge isn't paid when due or within the grace period
 - The subscriber dies or is otherwise no longer eligible as a subscriber

- The Participating Employer's membership in the association ceases
- In the case of a collectively bargained plan, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she cannot meet the requirements for dependent coverage shown under the "Who Is Eligible For Coverage?" section.

The subscriber must promptly notify the Participating Employer when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. We must receive written notice of a member's termination within 30 days of the date the Participating Employer is notified of such event.

CONTRACT TERMINATION

No rights are vested under this plan. Termination of the Group Contract for this plan completely ends all members' coverage and all our obligations, except as provided under "Extended Benefits"; please see the "How Do I Continue Coverage?" section below.

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

The Group may terminate the Group Contract:

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

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

- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage
- The Group fails to meet the minimum participation or contribution requirements stated in its signed application
- The Group no longer has any members who reside or work in Washington
- Published policies, approved by the Office of the Insurance Commissioner, have been violated
- There is a material breach of the Group Contract, other than non-payment
- Changes in or implementation of federal state laws that no longer permit the continued offering of the Group Contract
- We discontinue this Group Contract, as allowed by law
- We are otherwise permitted to do so by law

For the timeliness of the delivery of our notice, please see "Notices" in "Other Information About this Plan."

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age (shown under "Dependent Eligibility") for a dependent child who can't support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes us with a Request for Certification of Handicapped Dependent form. We must approve the request for certification for coverage to continue.

- The subscriber provides us with proof of the child's disability and dependent status when we request it. We won't ask for proof more often than once a year after the 2-year period following the child's attainment of the limiting age.

LEAVE OF ABSENCE

Family and Medical Leave Act

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

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

The subscriber must pay his or her normal share of the subscription charges during the leave.

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

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

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

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

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

Other Leaves of Absence

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

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

LABOR DISPUTE

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

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

COBRA

When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations known as "COBRA" require the Group to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay the subscription charges for it. WA Farm Bureau Healthcare Trust and Premera Blue Cross have agreed that COBRA coverage will be a part of this plan for all Participating Employers.

At the Group's request, we'll provide qualified members with COBRA coverage under this plan when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us or the Participating Employer's failure to perform COBRA-related duties. The Participating Employer, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

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

Qualifying Events And Length Of Coverage

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

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

- The Participating Employer must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
 - **The subscriber's work hours are reduced.**
 - **The subscriber's employment terminates, except for discharge due to actions defined by the Participating Employer as gross misconduct.**

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

- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Participating Employer must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
 - **The subscriber dies.**
 - **The subscriber and spouse legally separate or divorce.**
 - **The subscriber becomes entitled to Medicare.**
 - **A child loses eligibility for dependent coverage.**

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

Conditions Of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage.

Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Participating Employer. The notice period starts on the date shown below.

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

Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See "When COBRA Coverage Ends."

- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

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

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

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

You Must Enroll And Pay On Time

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

Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

If you're not notified of your right to elect COBRA coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you're not notified of your right to elect COBRA coverage within the time limit, and you don't elect COBRA coverage within 60 days after the date coverage

ends, we won't be obligated to provide COBRA benefits under this plan. The Participating Employer will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.

- You must send your first subscription charge payment to the Participating Employer no more than 45 days after the date you elected COBRA coverage.
- Subsequent subscription charges must be paid to the Participating Employer and submitted to us with the Group's regular monthly billings.

Adding Family Members

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

Keep The Participating Employer Informed Of Address Changes

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

When COBRA Coverage Ends

COBRA coverage will end on the last day for which subscription charges have been paid in the monthly period in which the first of the following occurs:

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

However, even if one of the events above hasn't occurred, COBRA coverage **under this plan** will end on the date that the contract between the Group and us is terminated or the date that coverage under this plan ends for the Participating Employer.

When COBRA coverage under this plan ends, you may be eligible for benefits as described in "Extended Benefits" later in this section. You may also be eligible to apply for one of our individual plans as explained in "Converting To A Non-Group Plan" later in this section.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Participating Employer. For more information about your rights under federal laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

3-MONTH CONTINUATION OF GROUP COVERAGE

You may choose to extend your coverage under this plan for up to 3 months past the date your coverage ended if:

- Your Participating Employer isn't subject to COBRA.
- You're not eligible for COBRA coverage.
- Your group coverage ends for reasons other than as described under "Intentionally False Or Misleading Statements."

You must send your first subscription charge payment and completed application to the Participating Employer by the due date determined by the Group. The Group will in turn send us your subscription charge payment and completed application form with the first payment it makes on or after the date your coverage ended. Subsequent subscription charge payments must be paid to the Participating Employer, by the date determined by the Group, and forwarded to us by the Group with their regular monthly billings.

Continued coverage under this plan may end before the 3-month period expires. It will end on the last day of the monthly period for which subscription charges have been paid in which the first of the following occurs:

- The next monthly subscription charge isn't paid when due or within the grace period
- The contract between the Group and us is terminated
- The Participating Employer's coverage under this plan is terminated

The 3-month continuation period isn't available once COBRA coverage is exhausted.

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than as described under "Intentionally False Or Misleading Statements." If the contract between the Group and us is terminated while you're receiving the extended benefits below, your right to those benefits won't be affected.

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

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

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

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

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

CONTINUATION UNDER USERRA

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

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

CONVERTING TO A NON-GROUP PLAN

You may be entitled to coverage under an Individual plan when your coverage under this plan ends. Individual plans differ from this plan. You pay the monthly payment. You must apply and send the first subscription charge payment within 60 days of the date your coverage ends or you were first notified that your coverage had ended under this plan, whichever is later.

You can apply for an Individual plan if you live in Washington State and you're not eligible for Medicare coverage, and you're not entitled to services or benefits for medical and hospital care under another group plan.

For more information about Individual plans, contact your employer or our Customer Service department.

Please Note: The rates, coverage and eligibility requirements of Individual plans differ from those of your current group plan.

MEDICARE SUPPLEMENT COVERAGE

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you **may** be eligible for guarantee-issued coverage under certain Medicare supplement plans if you apply within 63 days of losing coverage under this plan. For more information, contact your producer or our Customer Service department.

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:

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.

Non-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 network mail-order pharmacy order forms or prescription drug claim forms, contact our Customer Service department at the numbers shown on the back cover of this booklet.

Timely Filing

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

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

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

Special Notice About Claims Procedure

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

If your claim was denied, in whole or in part, our written notice (see "Notices") will include:

- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information we may need to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of our complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter from our medical department stating these reasons. The letter will also include how ongoing care may be covered during the appeal process, as described in "When You Have An Appeal" below.

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

If all you have to pay is a copay for a covered service or supply, it is not considered a claim for benefits. However, you always have the right to get a paper copy of your explanation of benefits for the service or supply. You can call Customer Service. The phone number is on the back cover of your booklet and on your Premiera Blue Cross ID card. Or, you can visit our website for secure online access to your claims. If your claim is denied in whole or in part, you may send us a complaint or appeal as outlined under "Complaints And Appeals."

If your Participating Employer is subject to ERISA, ERISA gives you the right to file suit in a state or federal court if a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in these claims procedures.

COMPLAINTS AND APPEALS

As a Premiera Blue Cross member, you have the right to offer your ideas, ask questions, voice complaints and request a formal appeal to reconsider decisions we have made. Our goal is to listen to your concerns and improve our service to you.

If you need an interpreter to help with oral translation, please call us. Customer Service will be able to guide you through the service.

WHEN YOU HAVE IDEAS

We would like to hear from you. If you have an idea, suggestion, or opinion, please let us know. You can contact us at the addresses and telephone numbers found on the back cover.

WHEN YOU HAVE QUESTIONS

Please call us when you have questions about a benefit or coverage decision, our services, or the quality or availability of a healthcare service, or our service. We can quickly and informally correct errors, clarify benefits, or take steps to improve our service.

We suggest that you call your provider of care when you have questions about the healthcare they provide.

WHEN YOU HAVE A COMPLAINT

You can call or write to us when you have a complaint about a benefit or coverage decision, Customer Service, or the quality or availability of a health care service. We recommend, but don't require, that you take advantage of this process when you have a concern about a benefit or coverage decision. There may be times when Customer Service will ask you to submit your complaint for review through the formal internal appeals process outlined below.

We will review your complaint and notify you of the outcome and the reasons for our decision as soon as possible, but no later than 30 days from the date we received your complaint.

WHEN YOU DO NOT AGREE WITH A PAYMENT OR BENEFIT DECISION

If we declined to provide payment or benefits in whole or in part, and you disagree with that decision, you have the right to request that we review that adverse benefit determination through a formal, internal appeals process.

This plan's appeals process will comply with any new requirements as necessary under state and federal laws and regulations.

What is an 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, investigational, not medically necessary or appropriate, or not effective.

WHEN YOU HAVE AN APPEAL

After you find out about an adverse benefit decision, you can ask for an internal appeal. Your plan has two levels of internal appeals. Your Level I internal appeal will be reviewed by people who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be done by a provider. They will review all of the information about your appeal and will give you a written decision. If you are not satisfied with the decision, you may request a Level II appeal.

Your Level II internal appeal will be reviewed by a panel of people who were not involved in the Level I appeal. If the adverse benefit determination involved medical judgment, a provider will be on the panel. You may take part in the Level II panel meeting in person or by phone. Please contact us for more details about this process.

Once the Level II review is done, we will give you a written decision.

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

Who may file an internal appeal?

You may file an appeal for yourself. You can also appoint someone to do it for you. This can be your doctor or provider. To appoint a representative, you must sign an authorization form and send it to us. The address and fax number are listed on the back cover. This release gives us your approval for this person to appeal on your behalf and allows our release of information, if any, to them. If you appoint someone else to act for you, that person can do any of the tasks listed below that you would need to do.

Please call us for an Authorization For Release form. You can also get a copy of this form on our website at www.premera.com.

How do I file an internal appeal?

You may file an appeal by calling Customer Service or by writing to us at the address listed on the back cover of this booklet. We must receive your appeal request as follows:

- For a Level I internal appeal, within 180 calendar days of the date you were notified of the adverse benefit determination.
- For a Level II internal appeal, within 60 calendar days of the date you were notified of the Level I determination. If you are in the hospital or away from home, or for other reasonable cause beyond your control, we will extend this time limit up to 180 calendar days to allow you to get medical records or other documents you want us to look at.

You may send your written appeal request to the address or fax number on the back cover of this booklet.

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on the back cover of this benefit booklet. You can also get a description of the appeals process by visiting our website at www.premera.com.

We will confirm in writing that we have your request within 72 hours.

What if my situation is clinically urgent?

If your provider believes that situation is urgent under law, your appeal will be conducted on an expedited basis; for example:

- Your doctor thinks a delay may put your life or health in serious jeopardy or would subject you to pain that you cannot tolerate
- The appeal is related to inpatient or emergency services and you are still in the emergency room or in the ambulance

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements. Please call Customer Service if you want to expedite your appeal. The number is listed on the back cover of this booklet.

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

Can I provide more information for my appeal?

You may give us more information to support your appeal either at the time you file an appeal or at a later date. Mail or fax the information to the address and fax number listed on the back cover of this booklet. Please give us this information as soon as you can.

Can I get copies of information relevant to my appeal?

We will also send you any new or additional information we considered, relied upon or generated in connection to your appeal. We will send it as soon as possible and free of charge. You will have the chance to review it and respond to us before we make our decision.

What happens next?

We will review your appeal and give you a written decision within the time limits below:

- For expedited appeals, as soon as possible, but no later than 72 hours after we got your request. We will call, fax or email and then follow up in writing.
- For appeals for benefit decisions made before you received the services, within 14 days of the date we got your request.
- For all other appeals, excluding experimental and investigational appeals, within 14 days of the date we got your request. If we need more time to review your request, we may extend the review to no more than 30 days, unless we ask for and receive your agreement for more time after the 30 days.

We will send you a notice (see "Notices") of our decision and the reasons for it. If we uphold our initial decision, we will tell you about your right to a Level II internal appeal or to an external review at the end of the internal appeals process. You can also go to the next appeal step if we do not comply with the rules above when we handle your appeal.

Appeals about ongoing care

If you appeal a decision to change, reduce or end coverage of ongoing care because the service is no longer medically necessary or appropriate, we will suspend our denial of benefits during the appeal period. Our provision of benefits for services received during the internal appeal period does not, and should not be assumed to, reverse our denial. If our decision is upheld, you must repay us all amounts that we paid for such services. You will also be responsible for any difference between our allowable charge and the provider's billed charge if the provider is non-contracting.

WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an independent review organization (IRO) that is certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

If we deny your internal appeal, we will tell you about your rights to an external review and send you an IRO release form. We must receive your written request for an external review and the signed release form within 180 days of the date of our appeal response.

You can ask us to expedite the external review when your provider believes that your situation is clinically urgent under law.

When we receive your external appeal request, we will tell the IRO that you asked for an external review and forward your entire appeal file. We will also let you or your authorized appeals representative know where more information may be sent directly to the IRO and when the information must be sent. We will give the IRO any other information they ask for that is reasonably available to us.

When the IRO completes the external review

Once the external review is done, the IRO will let you and us know their decision within the time limits below:

- For expedited external reviews, as soon as possible, but no later than 72 hours after receiving the request. The IRO will notify you and us immediately by phone, e-mail or fax and will follow up with a written decision by mail.
- All other reviews, within 15 days after the IRO gets all the information they need or 20 days from the date the IRO gets your request, whichever comes first.

What Happens Next?

Premera Blue Cross is bound by the IRO's decision. If the IRO overturned our decision, we will implement their decision in a timely manner.

If the IRO upheld our decision, there is no further review available under this plan's appeal process. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Blue Cross Customer Service at the number listed on the back cover. If you want to make a complaint or need help filing an appeal, you can also contact the Washington Consumer Assistance Program at any time during this process.

If your plan is governed by the Federal Employee Retirement Income Security Act of 1974 (ERISA), you can also contact the Employee Benefits Security Administration of the U.S. Department of Labor.

Washington Consumer Assistance Program
5000 Capitol Blvd.
Tumwater, WA 98501
1-800-562-6900
E-mail: cap@oic.wa.gov

Employee Benefits Security Administration (EBSA)
1-866-444-EBSA (3272)

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

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

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

You may also ask Customer Service for more information about:

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

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Entire Contract

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

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

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

Evidence Of Medical Necessity

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

The Group And You

The Group and the Participating Employer are your representatives for all purposes under this plan and not the representatives of Premera Blue Cross. Any action taken by the Group or Participating Employer will be binding on you.

Intentionally False Or Misleading Statements

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

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

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

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

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

Member Cooperation

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

Notice Of Information Use And Disclosure

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

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

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

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

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

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

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

Notice Of Other Coverage

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

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

Notices

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

Right Of Recovery

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

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

Right To And Payment Of Benefits

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

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

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

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

Venue

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

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

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

Workers' Compensation Insurance

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

WHAT ARE MY RIGHTS UNDER ERISA?

The Participating Employer may have an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). If so, this section of the booklet describes subscriber's rights under ERISA. Please see the Participating Employer to find out if this plan is subject to ERISA.

This employee welfare benefit plan is called the "ERISA Plan" in this section. The insured Premera Blue Cross plan described in this booklet is part of the ERISA Plan. For purposes of ERISA only, this plan is considered a separate plan for each Participating Employer.

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

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

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. (Please note that our contract with the Group by itself does not meet all the requirements for an ERISA plan document.) If the ERISA Plan is required to file an annual report with the U.S.

Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event and the Participating Employer is required by law to offer COBRA coverage. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. (Premera Blue Cross is a fiduciary only with respect to claims processing and payment.) No one, including your employer, the Group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

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

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

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

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

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

DEFINITIONS

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

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).

Allowable Charge

This plan provides benefits based on the allowable charge for covered services. We reserve the right to determine the amount allowed for any given service or supply. The allowable charge is described below. There are different rules for dialysis due to end-stage renal disease and for emergency services. These rules are shown below the general rules.

General Rules

• Providers In Washington and Alaska Who Have Agreements With Us

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

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

• 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, allowable charges are determined as stated in the "What Do I Do If I'm Outside Washington And Alaska?" section ("Out-Of-Area Care") in this booklet.

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

The allowable charge for providers in the service area that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside the service area that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

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

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

Dialysis Due To End Stage Renal Disease

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

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

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

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

The amount the plan allows for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

See the Dialysis benefit for more details.

Emergency Care

Consistent with the requirements of the Affordable Care Act, the allowable charge will be the greatest of the following amounts:

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

In addition to your deductible, copays and coinsurance, you will be responsible for charges received from non-network providers above the allowable charge.

When you receive services from providers that **don't** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowable charge, and for your normal share of the allowable charge (see the "What Are My Benefits?" section for further detail).

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

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

Ambulatory 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

Calendar Year

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

Chemical Dependency

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

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

Community Mental Health Agency

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

Congenital Anomaly Of A Dependent Child

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

Cost-Share

The member's share of the allowable charge for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See "What Are My Benefits" to find out what your cost-share is.

Custodial Care

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

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury

- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel

Detoxification

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

Drug Benefit Manager

An entity that contracts with us to administer prescription drug benefits under this plan.

Effective Date

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

Eligibility Waiting Period

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

Emergency Care

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
- Ambulance transport as needed in support of the services above.

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency care, hospitalization, maternity and newborn care, mental health and chemical dependency services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Experimental/Investigational Services

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

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

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

Group

A trust or other entity that is made up of multiple participating employers. The workforces of all participating employers combined must have been an average of at least 51 common law employees on the participating employers' business days during the preceding calendar year. The combined workforce must also be an average of at least 51 common law employees on the first day of the current Contract Term.

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

Hospital

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

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

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

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

Illness

A sickness, disease, medical condition or pregnancy.

Injury

Physical harm caused by a sudden event at a specific time and place. It's independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical Emergency

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

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

Medical Equipment

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

Medical Facility (also called "Facility")

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

Medically Necessary

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

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" and "Your")

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

Network Pharmacy (Network Retail/Network Mail Order Pharmacy)

A licensed pharmacy which contracts with us or our Pharmacy Benefits Administrator to provide prescription drug benefits.

Network Provider

A provider that is in one of the networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Non-Contracted Provider

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

Non-Network Provider

A provider that is not in one of the provider networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Obstetrical Care

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

Abortion is included as part of obstetrical care.

Orthodontia

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

Orthotic

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

Outpatient

Treatment received in a setting other than an inpatient in a medical facility.

Participating Employer

The corporation, partnership, proprietorship, government, governmental agency, or other organization, unit or entity that is engaged in business and is accepted by the Group as a member of the Group.

Physician

A state-licensed:

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

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

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

Plan (also called "This Plan")

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

Prescription Drug

Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
 - **The American Hospital Formulary Service-Drug Information**
 - **The American Medical Association Drug Evaluation**
 - **The United States Pharmacopoeia-Drug Information**
 - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

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

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

Provider

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

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

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

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

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

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals

- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

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

Psychiatric Condition

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

Service Area

The states of Washington (except Clark County) and Alaska

Skilled Care

Care that's ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

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

Subscriber

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

Subscription Charges

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

Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

We, Us and Our

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

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

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

Contact the Drug Benefit Manager At
1-800-391-9701
www.express-scripts.com

Customer Service

Mailing Address

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

Physical Address

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

Phone Numbers

Local and toll-free number:
1-800-722-1471

Local and toll-free TTY number:
1-800-842-5357

Care Management

Prior Authorization And Emergency Notification

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

Local and toll-free number:
1-800-722-1471
Fax: 1-800-843-1114

Telehealth

You can get telehealth care from Teladoc. Log onto your account at member.teladoc.com/premera or call 1-855-332-4059.

Complaints And Appeals

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

BlueCard

1-800-810-BLUE(2583)

Website

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