Your World™
Retiree Without Medicare Plan

1037338

PREMERA BLUE CROSS

INTRODUCTION

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

Grant County has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. Grant County has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent stated in our administrative services contract with the Group. Premera Blue Cross doesn't insure this plan. In this booklet Premera Blue Cross is called the "Claims Administrator." This booklet replaces any other benefit booklet you may have.

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 providers that we have agreements with 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 requirement.
- **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.

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:

- 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

Group Name:	Grant County
Effective Date:	January 1, 2015
Group Number:	1037338
Plan:	Your World – Retiree Without Medicare Plan
Certificate Form Number:	GC Ret-w-Med2015-E

TABLE OF CONTENTS

CONTACT THE CLAIMS ADMINISTRATOR .....(SEE BACK COVER OF THIS BOOKLET)

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

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING? 1

WHAT ARE MY BENEFITS?.....2

Medical Services 3

Vision Exams 16

Prescription Drugs.....16

WHAT DO I DO IF I'M OUTSIDE WASHINGTON AND ALASKA? 20

BlueCard® Program And Other Inter-Plan Arrangements 20

CARE MANAGEMENT 21

Prior Authorization.....21

Clinical Review.....22

Case Management.....22

WHAT'S NOT COVERED? 22

Waiting Period For Transplants 22

Limited And Non-Covered Services.....22

WHAT IF I HAVE OTHER COVERAGE? 27

Coordinating Benefits With Other Health Care Plans 27

Subrogation And Reimbursement.....29

Uninsured And Underinsured Motorist/Personal Injury Protection Coverage.....29

WHO IS ELIGIBLE FOR COVERAGE? 29

Subscriber Eligibility 30

Dependent Eligibility.....30

WHEN DOES COVERAGE BEGIN? 30

Enrollment 30

Special Enrollment 31

Open Enrollment/Change in Family Status.....32

Changes In Coverage 33

Plan Transfers.....33

WHEN WILL MY COVERAGE END?.....33

Events That End Coverage.....33

Plan Termination 33

HOW DO I CONTINUE COVERAGE?.....33

Continued Eligibility For A Disabled Child.....33

Leave Of Absence.....34

Labor Dispute 34

COBRA....34
3-Month Continuation Of Group Coverage....36
Continuation Under USERRA....36
Medicare Supplement Coverage....36
HOW DO I FILE A CLAIM?....36
COMPLAINTS AND APPEALS....38
When You Have Questions....38
When You Have A Complaint....38
When You Have An Appeal....38
OTHER INFORMATION ABOUT THIS PLAN....39
DEFINITIONS....40

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

This plan provides you benefits for covered services from providers of your choice.

It uses our Global network in Washington, which is our broadest network. It is made up of all providers contracted with us in Washington. In Alaska, this plan gives you access to all providers who have contracts with Premera Blue Cross Blue Shield of Alaska. For care in Clark County, Washington or outside Washington and Alaska, this plan also gives you access to providers contracted with the Traditional (participating) provider networks of local Blue Cross and/or Blue Shield Licensees ("Host Blues").

This plan's cost-shares for the above contracted providers are the same as they are for other covered providers.

However, the contracted providers provide medical care to members at negotiated fees. These fees are the allowable charges for these providers. Contracted providers will not charge you more than the allowable charge for covered services. For this reason, your portion of the charges for covered services is lower. Global providers are also familiar with this plan's features and can help you make informed decisions about the healthcare you get.

You may access current information on contracted providers at any time on our Web site at **www.premera.com**. You may also call 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 Traditional provider. The numbers are on the back cover of this booklet and on your Premera Blue Cross ID card.

Other Providers

This plan covers providers who are not contracted as described above.

- Providers that are not in a Host Blue's Traditional network may still have a contract with the Host Blue. These providers will not bill you for any amount above the allowable charge for a covered service.
- 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 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 contracted facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are not contracted providers. When you receive services from these providers, you may be responsible for amounts over the allowable charge as explained above.

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. 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.

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). Copays don't count toward the calendar year deductible.

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 coinsurance 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.

COINSURANCE MAXIMUM

The "individual coinsurance maximum" is the maximum amount, made up of the coinsurance that each individual could pay each calendar year for certain covered services and supplies.

In addition to benefits shown under the "Medical Services" section of this plan accruing to your coinsurance maximum, benefits for routine vision exams and testing will also accrue to your coinsurance maximum.

Please refer to "What's My Coinsurance Maximum?" in the "What Are My Benefits?" section for the amount of any coinsurance maximums you're responsible for.

Once the coinsurance maximum has been satisfied, the benefits of this plan will be provided at 100% of allowable charges for the remainder of that calendar year.

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 the 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 and after any applicable waiting period required under this plan is satisfied
- 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.

WHAT'S MY CALENDAR YEAR DEDUCTIBLE?

Individual Calendar Year Deductible

For each member, this amount is $500.

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 calendar year deductible toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to your individual calendar year deductible toward that maximum.

Family Deductible

The maximum calendar year deductible for your family is $1,500.

Please Note: The calendar year deductible doesn't accrue toward the coinsurance maximum.

Fourth Quarter Carryover

Expenses you incur for covered services and supplies in the last 3 months of a calendar year which are used to satisfy all or part of the calendar

year deductible **will also** be used to satisfy all or part of the next year's deductible.

WHAT'S MY COINSURANCE?

Your coinsurance is 20% of allowable charges.

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

- The Transplants benefit
- The Health Management benefit
- The Home Health Care benefit
- The Hospice Care benefit
- The Orthognathic Surgery benefit
- The Prescription Drugs benefit
- The Private Duty Nursing Care benefit

WHAT'S MY COINSURANCE MAXIMUM?

Individual Coinsurance Maximum

For each member, this amount is $10,000 per calendar year.

DOES MY PLAN HAVE A LIFETIME MAXIMUM?

The lifetime maximum amount of benefits for services described in this booklet that are available to any one member is $2,000,000.

Annual Restoration Each January 1 of your continuous coverage, we will restore up to $5,000 of your lifetime maximum that has been paid by the plan and not previously restored. This restoration occurs regardless of the state of your health.

The following benefits don't accrue to your lifetime maximum:

- Benefits described in the "Prescription Drugs" section

It's important to note that certain benefits of this plan are also subject to separate lifetime benefit maximums.

MEDICAL SERVICES

Acupuncture Services

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

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 24 visits per member per calendar year.

Ambulance Services

Benefits for the following services are subject to your 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. This benefit only covers the member that requires transportation.

Ambulatory Surgical Center Services

These services are subject to your calendar year deductible and coinsurance. 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.

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.

Most benefits are subject to the same calendar year deductible and coinsurance, 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

Chemotherapy, Radium Or X-ray Therapy

Benefits are provided for chemotherapy, radium or x-ray therapy, subject to your calendar year deductible and coinsurance.

Contraceptive Management And Sterilization

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

Contraceptive Management and Sterilization Procedures

Benefits are provided for the following:

- Consultations
- Sterilization procedures
- Injectable contraceptives
- Implantable contraceptives (including hormonal implants)
- Emergency contraception methods (oral or injectable), when furnished by your health care provider

Prescription Contraceptives Dispensed By A Pharmacy

Prescription contraceptives (including emergency contraception) and prescription barrier devices, such as diaphragms and cervical caps, dispensed by a licensed pharmacy are covered on the same basis as any other covered prescription drug. Please see the Prescription Drugs benefit.

The Contraceptive Management and Sterilization benefit doesn't cover:

- Non-prescription contraceptive drugs, supplies or devices
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Dental Services

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

Care For Injuries

Benefits for the following services are subject to your calendar year deductible and coinsurance. Care for dental injuries will be provided up to a benefit maximum of $1,000 per calendar year.

When services are related to an injury, benefits are provided for the repreparation 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 the plan's extension criteria. We must receive extension requests within 12 months of the injury date.

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

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 7 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

Benefits for these services are subject to your calendar year deductible and coinsurance.

The Diagnostic Services benefit covers diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Screening tests for prostate and cervical cancer.
- Colon cancer screening. Includes exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Coverage for colonoscopy and sigmoidoscopy includes medically necessary sedation. Please note that the use of an anesthesiologist for monitoring and administering general anesthesia for colon health screenings is not covered unless medically necessary, when specific medical conditions and risk factors are present. You can find a list of conditions and other details in the medical policy at **www.premera.com**.
- Diagnostic imaging and scans (including x-rays and EKGs)
- Laboratory services, including routine and preventive
- Pathology tests

Please Note:

- Diagnostic surgeries, including scope insertion procedures, such as endoscopies or colonoscopies, can only be covered under the Surgical Services benefit.
- Allergy testing is covered only under the Professional Visits and Services benefit.
- When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit.
- When outpatient diagnostic services 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.

For mammography services, please see the Diagnostic and Screening Mammography benefit.

Diagnostic and Screening Mammography

Benefits for these services are subject to your calendar year deductible and coinsurance.

The Diagnostic and Screening Mammography benefit covers diagnostic and screening 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.

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 for dialysis is waived.

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

If the dialysis services are provided by a non-network provider then you will owe the difference between the non-network 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

Emergency room services are subject to your calendar year deductible and coinsurance.

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.

Health Management

Benefits are only provided when the following services are furnished by contracted or approved providers or facilities. To obtain a list of contracted or approved providers or facilities, contact our Customer Service department.

Health Education

These services are provided at 100% of allowable charges (your calendar year deductible is waived), and are covered up to a maximum benefit of $250

per member each calendar year for outpatient health education services.

Benefits are provided for outpatient health education services to manage a covered condition, illness or injury. Examples of covered health education services are asthma, pain management, childbirth and newborn parenting and lactation.

Diabetes Health Education

These services are subject to a constant 20% coinsurance (your calendar year deductible is waived), up to a maximum benefit of $250 per member each calendar year for diabetes health education services. These services don't accrue to your coinsurance maximum.

Benefits are provided for outpatient health education and training services to manage the condition of diabetes.

Community Wellness

These services are provided at 100% of allowable charges (your calendar year deductible is waived), and are covered up to a maximum benefit of $250 per member each calendar year for community wellness services.

Community wellness classes and programs that promote positive health and lifestyle choices are also covered. Examples of these classes and programs are adult, child, infant and CPR, safety, back pain prevention, stress management, bicycle safety, and parenting skills. You pay for the cost of the class or program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

Many of our network hospitals offer a variety of community wellness classes and programs. To find out whether the provider you have chosen is approved, please contact our Customer Service department.

Nicotine Dependency Programs

These services are provided at 100% of allowable charges (your calendar year deductible is waived), and are covered up to a maximum benefit of $250 per member each calendar year for nicotine dependency programs.

Benefits are provided for nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated above in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

Prescription drugs for the treatment of nicotine dependency are also covered under this plan. Please see the Prescription Drugs benefit.

Home and Hospice Care

Benefits for home health and hospice services are subject to your calendar year deductible and then covered at 100% of allowable charges.

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. (Such equipment and supplies are not subject to the benefit maximums stated in the Medical Equipment and Supplies benefit.)

Home Health Care

This benefit provides up to combined 130 intermittent home visits and outpatient professional home infusion therapy visits per member each calendar year. These services need to be provided 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.

Benefits for home infusion therapy services are provided at 100% of allowable charges (your calendar year deductible is waived).

Hospice Care

Benefits for a terminally ill member shall not exceed 6 months of covered hospice care. Benefits may be provided for an additional 6 months of care in cases where the member is facing imminent death or is

entering remission. The initial 6-month period starts on the first day of covered hospice care. 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** 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 isn't subject to a calendar year benefit maximum.

Home Infusion Therapy Drugs And Solutions

Benefits for home infusion therapy drugs and solutions are subject to your coinsurance (Your calendar year deductible is waived).

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

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

Benefits for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice are subject to your calendar year deductible then covered at 100% of allowable charges.

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

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

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

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

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 coinsurance (your deductible is waived).

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. 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 for the following services are subject to your calendar year deductible and coinsurance.

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

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

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

Medical Equipment and Supplies

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

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.

Benefits for medical supplies, orthotics (other than foot orthotics), and orthopedic appliances are not subject to a benefit maximum.

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.

Benefits for prosthetics are not subject to a benefit maximum.

Foot Orthotics and Therapeutic Shoes

Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses. Therapeutic shoes are subject to a $600 maximum benefit per calendar year. Coverage for medically necessary casted foot orthotics are subject to a separate $600 benefit maximum per calendar

year. Items prescribed for the treatment of diabetes are subject to these limits.

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
- 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.

Medical Foods

Benefits for medical foods, as defined below, are subject to your calendar year deductible and then covered at 100% of allowable charges.

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). In some cases of severe malabsorption (eosinophilic gastrointestinal disease), a medical food called "elemental formula" may be covered.

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, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar 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 and coinsurance, 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

Covered mental health services are inpatient care and outpatient therapeutic visits to manage or lessen the effects of a psychiatric condition. Benefits also cover physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders.

"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 **Physician's Current Procedural Terminology**, published by the American Medical Association.

Covered services must be furnished by one of the following types of providers:

- 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.

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.

The Mental Health benefit doesn't cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback that is deemed experimental or investigational treatment for the condition. Biofeedback for generalized anxiety disorder is covered
- 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 for the following services are subject to your calendar year deductible and coinsurance.

Benefits are provided for the treatment of neurodevelopmental disabilities for members under the age of 7. 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 approved by us, and will only be covered when services can't be done in a less intensive setting.

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 approved by us, 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 60 visits per member each calendar year.

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

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

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

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.

Professional Care

Benefits for services received in a provider's office are subject to the terms of the Professional Visit benefit. This benefit covers:

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

Please Note: Attending provider as used in this benefit means a 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.

Nutritional Therapy

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

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. Nutritional therapy for conditions other than diabetes or eating disorders is limited to 4 visits per member each calendar year. Nutritional therapy for the condition of diabetes or for eating disorders isn't subject to a calendar year benefit limit.

Obstetrical Care

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

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for the subscriber or enrolled spouse. Pregnancy and childbirth benefits aren't covered for dependent children. However, complications of pregnancy are covered on the same basis as any other illness for the subscriber, enrolled spouse, or enrolled dependent child.

The Obstetrical Care benefit includes coverage for voluntary termination of pregnancy.

Facility Care

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

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

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

Professional Care

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

Please Note: Attending provider as used in this benefit means a 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.

Orthognathic Surgery (Jaw Augmentation Or Reduction)

Benefits for the following services are subject to your calendar year deductible and then covered at 100% of allowable charges.

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) are provided up to a lifetime maximum benefit of $1,000 per member. These procedures are not covered under other benefits of this plan. The only exception to this benefit maximum is treatment needed to repair a dependent child's congenital anomaly.

Private Duty Nursing Care

Benefits for private duty nursing care are subject to your calendar year deductible, then provided at 100% of allowable charges.

Benefits will be provided for special nursing care in the home, by a registered nurse or a licensed

practical nurse, up to a maximum of $5,000 per member per calendar year when:

- The services are medically necessary and
- Such care is prescribed by a physician

Professional Visits and Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home.

Outpatient Professional Exams and Visits

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

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")
- Diabetic foot care
- Repair of a dependent child's congenital anomaly

Therapeutic Injections And Allergy Tests

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

Benefits are available for the following:

- Therapeutic injections, including allergy injections
- Allergy testing

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 benefit information on contraceptive injections or implantable contraceptives, please see the Contraceptive Management and Sterilization 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

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

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

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

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 approved by us, 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.

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 approved by us, 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 60 visits per member each calendar year. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

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.

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 for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility. Skilled nursing facility services aren't subject to a benefit maximum.

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 the following services are subject to your calendar year deductible and coinsurance.

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition. Benefits for spinal and other manipulations aren't subject to a calendar year limit.

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.

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. Please note that the use of an anesthesiologist for monitoring and administering general anesthesia for colon health screenings is not covered unless medically necessary, when specific medical conditions and risk factors are present. You can find a list of

conditions and other details in the medical policy at www.premera.com.

- 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.

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

Temporomandibular Joint (TMJ) Disorders

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

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, up to a maximum benefit of $1,000 per member each calendar year. The lifetime maximum for these services is $5,000 per member.

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, as determined by us according to the criteria stated under "Definitions," or primarily for cosmetic purposes

Transplants

Waiting Period

This plan doesn't provide benefits for an organ, bone marrow or stem cell transplant, including any procedure associated with the transplant (for example, testing, blood typing, chemotherapy, radiation or hospitalization), unless you've been covered under a medical plan sponsored by the Group for 6 consecutive months. However, this waiting period doesn't apply if the transplant is needed as a direct result of:

- A congenital anomaly of a child who's been covered by a medical plan sponsored by the Group since birth
- A congenital anomaly of a child who's been covered by a medical plan sponsored by the Group since placement for adoption with the subscriber

This benefit covers medical services only if provided by "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Benefits are provided for inpatient and outpatient surgical facility services when you use an approved transplant center, and inpatient and outpatient professional services when you use an approved transplant provider. Benefits are subject to the same calendar year deductible, coinsurance or copays, as you would pay for inpatient services and outpatient visits for other covered medical conditions.

The transport and lodging benefits below are subject to your calendar year deductible (your coinsurance doesn't apply). 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.") The plan reserves the right to base coverage on all of the following:

- Organ transplants and bone marrow/stem cell reinfusion procedures must meet the plan's criteria for coverage. The medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives are all reviewed.

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

  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney

- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

  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).

- You've satisfied your waiting period.
- Your medical condition must meet the plan's written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An "approved transplant center" is a hospital or other provider that's developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) 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 written approval standards set by us.
- The $350,000 transplant maximum benefit must not have been reached.

Transplant Maximum

This benefit is subject to a lifetime maximum benefit of $350,000 for all covered transplants and transplant-related services combined. Services that accrue to this lifetime maximum benefit are also subject to the 6-month waiting period stated above.

Recipient Costs

Benefits for transplant or reinfusion-related expenses start accruing to the $350,000 maximum on the day before the date of the transplant, with one exception. If a member is admitted to the hospital for the preparation regimen for a bone marrow or stem cell reinfusion, benefits start accruing to the maximum on the date of admission. Benefits for all transplants and reinfusions stop accruing to the $350,000 maximum 100 days after the date of the transplant or reinfusion. Benefits for services received during a hospital admission that are not directly related to the transplant are covered as any other condition and will not accrue toward the transplant benefit maximum. However, the time limits above don't apply to this benefit's coverage for transportation and lodging.

This benefit also provides coverage for anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs

Procurement expenses are charged against the recipient's $350,000 maximum and are limited to $75,000 per transplant. The time limit in which recipient expenses accrue to the transplant maximum does not apply to covered donor costs. All covered donor costs accrue to the transplant maximum, no matter when the donor receives them. 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.

Transportation and Lodging Expenses

Reasonable and necessary expenses for transportation, lodging and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center unless medically necessary treatment protocols require the member to remain closer to the transplant center
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided up to a maximum of $125 per day
- When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided up to a maximum of $80 per day
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companions are charged against the recipient's $350,000 maximum and are limited to $7,500 per transplant

This 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

VISION EXAMS

Benefits for routine vision exam services are subject to your coinsurance (Your calendar year deductible is waived).

This benefit provides for one routine vision exam per member every 2 consecutive calendar years. Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

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

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

PRESCRIPTION DRUGS

The Prescription Drugs benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered under this benefit are injectable supplies. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of-pocket expense exceed the cost of the drug or supply.

The Prescription Drugs benefit requires you to pay either a copay or coinsurance for each separate new prescription or refill you get from participating pharmacies. The copay amounts and/or coinsurance percentages are shown below. A "copay" is a fixed up-front dollar amount that you're required to pay to the retail pharmacy or the participating mail-order pharmacy for each prescription drug purchase. "Coinsurance" is the percentage of the allowable charge that you're required to pay to the pharmacy for each prescription drug purchase.

See "Retail Pharmacy Benefit" later in this benefit for the additional amounts you would pay if you went to a non-participating retail pharmacy.

Please Note: Copays, deductibles, coinsurance and/or coinsurance maximums that may be required for other benefits of this plan don't apply to this benefit. Copays and coinsurance required under this benefit don't apply to other benefits of this plan.

Retail Pharmacy Prescriptions

Generic Drugs..... 35%

Preferred Brand 35%
Name Drugs

Non-Preferred Brand 35%
Name Drugs

Dispensing Limit

Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of up to a 90-day supply is allowed when the drug maker's packaging doesn't allow for a lesser amount. If any prescriptions require a copay, you would be charged an additional copay for each 30-day supply, or the cost of the drug if that cost doesn't exceed the cost of the copay.

How To Use The Retail Pharmacy Program

Retail Pharmacy Benefit

- **Participating Retail Pharmacies** After you've paid any required cost-share, the plan will pay the participating pharmacy directly.

  To avoid paying the retail cost for a prescription drug that's reimbursable at a lower allowable charge rate, be sure to present your identification card to the pharmacist for all prescription drug purchases.
- **Non-Participating Retail Pharmacies** You pay the full price for the drugs and submit a claim for reimbursement. Please see the "How Do I File A Claim?" section in this booklet for more information.

  After you've paid any required cost-share, you pay 40% of the allowable charge for the prescription or

refill and the difference between the pharmacy's billed charge and the allowable charge. This benefit applies to all prescriptions filled by a non-participating pharmacy, including those filled via mail or other home delivery.

If you need a list of participating pharmacies, please call us (see the back cover of this booklet). You can also call the toll-free Pharmacy Locator Line; this number is located on the back of your Premera Blue Cross ID card.

Medco By Mail / Mail-Order Pharmacy Program

Generic Drugs.....35%

Preferred Brand Name Drugs 35%

Non-Preferred Brand Name Drugs 35%

Dispensing Limit

Benefits are provided up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of a greater than a 90-day supply is permitted when the drug maker's packaging doesn't allow for a lesser amount. If any prescriptions require a copay, you would pay only 1 mail-order copay for each prescription when the drug maker's packaging exceeds the 90-day supply.

How To Use The Mail-Order Pharmacy Program

You can often save time and money by filling your prescriptions through the mail-order pharmacy program. After you've paid any required cost-share, the plan will pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by our participating mail-order pharmacy.

Ask your physician to prescribe needed medications for up to the maximum dispensing limit stated earlier in this benefit, plus refills. If you're presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a refill prescription to the mail-order pharmacy. Please see the "How Do I File A Claim?" section in this booklet for more information on submitting claims.

To obtain additional details about the mail-order pharmacy program, you may call our Customer Service department. You may also call the Pharmacy Benefit Administrator's Customer Service department or visit their Web site. You'll find the phone numbers and the Web address on the back cover of this booklet.

Please Note: Copays, deductibles, coinsurance and/or coinsurance maximums that may be required for other benefits of this plan don't apply to this benefit. Copays and coinsurance required under this benefit don't apply to other benefits of this plan.

Specialty Pharmacy Program

Specialty drugs are limited to a 30-day supply.

"Specialty drugs" are drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis or growth disorders (excluding idiopathic short stature without growth hormone deficiency).

Specialty pharmacies are pharmacies that focus on the delivery and clinical management of specialty drugs. You and your health care provider must work with a network specialty pharmacy to arrange ordering and delivery of these drugs. See "How Does Selecting A Provider Affect My Benefits?" for details about the provider networks.

Please note: This plan will only cover specialty drugs that are dispensed by a network specialty pharmacy. Contact Customer Service for details on which drugs are included in the specialty pharmacy program, or visit our Web site, which is shown on the back cover of this booklet.

What's Covered

This benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of "prescription drug" (please see the "Definitions" section in this booklet).
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Prescription drugs for the treatment of nicotine dependency, up to $250 per member each calendar year

- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps)

Injectable Supplies

When insulin needles and syringes are purchased along with insulin, only the cost-share for the insulin will apply.

When insulin needles and syringes are purchased separately, the Preferred List Brand Name Drug copay or coinsurance will apply for each item purchased.

The Preferred Brand Name Drug cost-share will apply to purchases for alcohol swabs, test strips, testing agents and lancets. If any prescriptions require a copay, a separate copay would apply to each item purchased.

Exclusions

This benefit doesn't cover:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but aren't limited to non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Non-participating mail-order pharmacies
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility. The exceptions are for growth hormones or drugs provided as part of the plan's Specialty Pharmacy provision (see "Specialty Pharmacy Program" earlier in this benefit, which are payable under this benefit, regardless of where they are administered.
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon, and growth hormones.) Please see the Infusion Therapy benefit.
- Drugs to treat sexual dysfunction
- Weight management drugs
- Drugs to treat infertility, including fertility enhancement medications
- Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit). Please see the Medical Equipment and Supplies benefit for available coverage.
- Immunization agents and vaccines, including the professional services to administer the medication.
- Drugs to treat infertility, including fertility enhancement medications

Prescription Drug Volume Discount Program

Your prescription drug program includes per-claim rebates that are received by Premera Blue Cross from its pharmacy benefit manager. These rebates are paid or credited to your group plan and are not reflected in your cost-share. The allowable charge that your payment is based upon for prescription drugs is higher than the price we pay our pharmacy benefit manager for those prescription drugs. The difference constitutes our property, and not part of the compensation payable to us under our contract with the Group. We are entitled to retain and shall retain the difference and may apply it to the cost of our operations and the prescription drug benefit program. If your prescription 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.

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?**

   The plan's prescription drug benefit makes use of our preferred drug list. (This sometimes is referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the preferred list.

   This plan encourages the use of appropriate "generic drugs" (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug.

   A "generic drug" is a prescription drug product manufactured and distributed after the brand name drug patent of the innovator company has

expired. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA 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.

It's important to note that this plan provides benefits for non-preferred brand name drugs, but at a higher cost to you.

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

This plan doesn't cover certain categories of drugs. These are listed above under "Exclusions."

2. When can my plan change the preferred drug list (formulary)? 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 preferred 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 preferred 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. The pharmacy's status as participating or non-participating on the date the drug is dispensed is also a factor.

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

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can only be changed at the sole discretion of the Group. Provisions regarding 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?

The amount you pay for covered drugs dispensed by a retail pharmacy or through the mail-order pharmacy benefit is described 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 participating pharmacies. Over 90% of the pharmacies (more than 1,000 individual pharmacies) in Washington are part of the participating pharmacy network. Your benefit covers prescription drugs dispensed from a non-participating pharmacy, but at a higher out-of-pocket cost to you as explained above.

You can find a participating 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.

Also see "Specialty Pharmacy Program" earlier in this benefit for information on specialty drugs.

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.

In certain circumstances, the plan may limit benefits to a specific dispensed days' supply, drug, or drug dosage appropriate for a usual course of treatment. The plan may also limit benefits for certain drugs to specific diagnoses or pharmacies or require prescriptions to be obtained from an appropriate medical specialist. Benefits for certain drugs may be subject to step therapy where you are required to first try a generic or specified brand name drug.

In making these determinations, medical necessity criteria, the recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines, published medical literature and standard reference compendia are all taken into consideration.

Benefits for refills will be provided only when the member has used 75% of the current supply. The 75% is calculated based on the number of units and days supply dispensed on the last refill.

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 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?

BLUECARD® PROGRAM AND OTHER INTER-PLAN ARRANGEMENTS

Premera Blue Cross has relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to non-network providers. Whenever you obtain healthcare services outside Washington and Alaska or in Clark County, Washington, the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when you receive covered services from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the “Host Blue” in this section. At times, you may also obtain care from non-network providers. Our payment calculation practices in both instances are described below.

It's important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

Network Providers

When you receive care from a Host Blue's network provider, you will receive many of the conveniences you’re used to from Premera Blue Cross. In most cases, there are no claim forms to submit because network providers will do that for you. In addition, your out-of-pocket costs may be less, as explained below.

Under the BlueCard Program, we remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever a claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

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

Often, this allowable charge will be a simple discount that reflects an actual price that the Host Blue considers payable to your provider. Sometimes, it is an estimated price that takes into account special arrangements with your provider that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the allowable charge we use for your claim because they will not be applied retroactively to claims already paid.

Clark County Providers

Some providers in Clark County, Washington 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.

Non-Network Providers

When covered services are provided outside Washington and Alaska or in Clark County, Washington by providers that do not have a contract with the Host Blue, the allowable charge will generally be based on either our allowable charge for these providers or the pricing requirements under applicable state law. You are responsible for the difference between the amount that the non-network provider bills and this plan's payment for the covered services.

Exceptions Required By Law

In some cases, federal law or the laws in a small number of states may require the Host Blue to include a surcharge as part of the liability for your covered services. If either federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then use the surcharge and/or other amount that the Host Blue instructs us to use in accordance with those laws as a basis for determining the plan's benefits and any amounts for which you are responsible.

BlueCard Worldwide®

If you’re outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide when accessing covered health services. BlueCard Worldwide is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although BlueCard Worldwide provides a network of

contracting inpatient hospitals, it offers only referrals to doctors and other outpatient providers. Also, when you receive care from doctors and other outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you'll typically have to submit the claims yourself to obtain reimbursement for these services.

Value-Based Programs

You might access covered services from providers that participate 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. Your subscription charges for this plan may also include an amount for VBP payments. If the Host Blue includes charges for these payments in the allowable charge on a claim, you would pay a part of these charges if a deductible, coinsurance, or copay applies to the claim. If the VBP pays the provider for coordinating your care with other providers, you will not be billed for it.

Further Questions?

If you have questions or need more information about the BlueCard Program, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, go to our Web site or call the toll-free BlueCard number; both are shown on the back cover of your booklet. 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 and to help us identify admissions that might benefit from case management.

PRIOR AUTHORIZATION

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

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 look at this list. The services, devices and drugs on the prior authorization list need to be reviewed to make sure that they are medically necessary for you and meet this plan's other standards for coverage. It is to your advantage to know in advance if the plan would not cover them.

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. Please see "How Does Selecting A Provider Affect My Benefits?" for details about network providers.

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 can call us at the number listed on your ID card to request a prior authorization. The non-network provider may agree to make the request for you. However, you should call us to make sure we have approved the prior authorization request in writing before you receive the services.

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.

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.
- 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.

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.

You can buy the prescription 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.

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 reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigational. A decision by Premera following this review may be appealed in the manner described in "Complaints And Appeals." When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

CASE MANAGEMENT

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care. Working together, we can make more efficient use of this plan's benefits. Your participation in a treatment plan through Case Management is voluntary.

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.

WAITING PERIOD FOR TRANSPLANTS

Organ, bone marrow and stem cell transplants are subject to a benefit-specific 6-month waiting period. Please see the Transplants benefit for details.

LIMITED AND NON-COVERED SERVICES

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

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 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 Health Management 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
- Genital surgery for the purpose of changing genital appearance
- Breast mastectomy or augmentation for the purpose of changing the appearance of the breasts, with or without chest reconstruction

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
- Repair of a dependent child's congenital anomaly
- 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 obesity drugs.

Counseling, Educational Or Training Services

- Counseling, education or training services, except as stated under the Chemical Dependency Treatment, Health Management, Nutritional Therapy and Mental Health Care benefits. 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

Court-Ordered Services

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

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 Dental Services (please see the "Medical Services" section under "What Are My Benefits?")

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

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, supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that don't require a prescription.

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:

- You're receiving care for a "medical emergency" (please see the "Definitions" section in this booklet)
- The plan 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

Hearing Hardware

Hearing aids and devices used to improve hearing sharpness

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Prescription Drugs benefit.

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

Immunizations

Immunizations, regardless of the reason.

Infertility, Assisted Reproduction And Sterilization Reversal

- Treatment of infertility, including procedures, supplies and drugs
- Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof
- Reversal of surgical sterilization, including any direct or indirect complications thereof

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, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit.
- 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.

Not Covered

- Services or supplies ordered when this plan isn't in effect, or when the person isn't covered under this plan
- Services or supplies provided to someone other than the ill or injured member, other than outpatient health education services covered under the Health Management benefit
- Services or supplies that aren't listed as covered under this plan
- Services or 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

Obesity Services

Treatment of obesity or morbid obesity, including surgery, and any direct or indirect complications and aftereffects thereof (An example of an aftereffect that would not be covered is removal of excess skin and or fat that developed as a result of weight loss surgery or the use of obesity drugs); services and supplies connected with weight loss or weight control, except for health education and wellness classes or programs specified as covered under the Health Management benefit and for services to treat diabetes covered under the Nutritional Therapy benefit. This exclusion applies even if you also have an illness or injury that might be helped by weight loss.

Online or Telephone Consultations And Telehealth Services

Benefits are not provided for electronic, telephone, online or Internet medical consultations or evaluations except the electronic visits covered under the Professional Visits and Services benefit. Coverage for psychiatric conditions is allowed for crisis/emergency evaluations or when the member is temporarily confined to bed for medical reasons.

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, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received.

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
- 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"

Pregnancy Of Dependent Children

Any care connected with a dependent child's pregnancy, except care furnished for the treatment of a complication of pregnancy.

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

- Routine or palliative foot care, including hygienic care
- Impression casting for foot prosthetics or appliances and prescriptions thereof

- Fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. However, foot-support supplies, devices and shoes are covered as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability
- Services and supplies that aren't directly related to your illness, injury or distinct physical symptoms. Examples are routine physical examinations and diagnostic surgery. However, this exclusion doesn't apply to services and supplies specified as covered under the following benefits:
  - Diagnostic Services
  - Diagnostic and Screening Mammography
  - Newborn Care
  - Health Management

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.

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 Hardware

Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies. Also not covered are non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

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

Voluntary Support Groups

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

Work-Related 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

This exclusion does not apply to subscribers who joined the Washington Law Enforcement Officers and Fire Fighters' retirement system before October 1, 1997. They will be covered under this plan for illness or injuries connected with their occupations as law enforcement officers or fire fighters.

Coverage is subject to the other terms and limitations of this plan.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

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

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

Definitions Applicable To Coordination Of Benefits

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

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

Allowable Dental Expense means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under any of the dental plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. For the purposes of this plan, only those dental services to treat an injury to natural teeth will be considered an allowable dental expense.

Claim Determination Period means a calendar year.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

Medical Plan means all of the following health care coverages, even if they don't have their own coordination provisions:

- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
- Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
- Government programs that provide benefits for their own civilian employees or their dependents
- Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation
- Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease

Dental Plan means all of the following dental care coverages, even if they don't have their own coordination provisions:

- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
- Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
- Government programs that provide benefits for their own civilian employees or their dependents

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

Effect On Benefits

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

payment amounts so that the total benefits from all medical plans aren't more than the allowable medical expenses and the total benefits from all dental plans aren't more than the total allowable dental expenses. We will coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

Primary And Secondary Rules

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

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

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

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

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

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

When the parents are divorced, separated or not living together, whether or not they were ever married:

- If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. 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 none of the rules above apply, the plans must share the allowable expenses equally.

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

Right Of Recovery/Facility Of Payment

The plan has the right to recover any payments that are greater than those required by the coordination of benefits provisions from one or more of the following: the persons the plan paid or for whom the plan has paid, providers of service, insurance companies, service plans or other organizations. If a payment that should have been made under this plan was made by another plan, the plan also has the right to pay directly to another plan any amount that the plan should have paid. Such payment will be considered a benefit under this plan and will meet the plan's obligations to the extent of that payment. This plan has the right to appoint a third party to act on its behalf in recovery efforts.

SUBROGATION AND REIMBURSEMENT

If the plan makes 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, the plan is entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or the plan. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor and because the plan excludes coverage for such benefits.

Definitions The following terms have specific meanings in this section:

- **Subrogation** means we may collect, on behalf of the plan, directly from third parties to the extent the plan has paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated to repay any monies advanced by the plan from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that the plan has to the monies advanced under your plan. Because the plan has paid for your illness or injuries, the plan is entitled to recover those expenses.

The plan is entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits the plan paid for the condition, whether or not you have been made whole for all your damages in the recoveries that you receive. The plan's right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. This right allows the plan to pursue any claim against any third party or insurer, whether or not you choose to pursue that claim. The plan's rights and priority are limited to the extent the plan has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights.

The plan's first priority right of reimbursement will not be reduced due to a member's own negligence; or due to a member not being made whole; or due to attorney's fees and costs under the "common fund" or any other doctrine.

In recovering benefits provided on behalf of the plan, we may at the Group's election hire an attorney or have the plan be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by the plan or the Group or on their behalf. If you retain an attorney or other agent to represent you in the matter, you must require that legal representative to reimburse the plan directly from the settlement or recovery. Before accepting any settlement on your claim against a third party, you or your legal representative must notify us in writing of any terms or conditions offered in a settlement, and you or your legal representative must notify the third party of the plan's interest in the settlement established by this provision. (See "Notices" later in this booklet.)You also must cooperate with us in recovering amounts paid by the plan on your behalf. If you or your legal representative fail to cooperate fully with us in the recovery of benefits the plan has paid as described above, you are responsible for reimbursing the plan for such benefits.

You or your legal representative must, within 14 business days of receiving a request from the plan, provide all information and sign and return all documents necessary to exercise the plan's right under this provision.

To the extent that you recover from any available third party source, you agree to hold any recovered fund in trust or in a segregated account until the plan's subrogation and reimbursement rights are fully determined.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

The plan has 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. The Group has the discretionary authority to determine your eligibility for benefits.

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.

RETIREE ELIGIBILITY

A person is eligible for retired employee coverage from the first day that he or she becomes a retired employee and was previously enrolled in the Grant County Health Insurance Plan. There are no waiting periods for the retired employee plan.

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 is recognized under Federal law.)
  - An eligible dependent child who is under 24 years of age and unmarried. (Eligibility and enrollment requirements for children placed for adoption and children covered because of a court decree can be found later in this section.) 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 **latest** of the applicable dates below.

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

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

If we don't receive the enrollment application within 60 days of the date you became eligible, none of the dates above apply. 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.

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 Group for detailed procedures.

SPECIAL ENROLLMENT

The plan allows employees and dependents who didn't enroll when they were first eligible or at the plan's last open enrollment period to enroll outside the plan's annual open enrollment period only in the cases listed below. If we don't receive a completed enrollment application within the time limits stated below, please see the "Open Enrollment" provision later in this section.

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, the reduction in the number of hours of employment, or reaching the other health care plan's overall lifetime benefit maximum
  - 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

In addition, if the eligible employee and/or dependent was covered under another health plan sponsored by the Group, and they reach that plan's lifetime maximum, they also have the right to enroll in this plan if one of two things is true:

- The lifetime maximum of this plan is higher than that of the other plan
- The benefits paid under the other plan could not be credited toward this plan's lifetime maximum. (See "Plan Transfers" later in this section for credits applied for transfers between two Premera Blue Cross plans.)

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/CHANGE IN FAMILY STATUS

If you're not enrolled when you first become eligible, or as allowed under "Special Enrollment" above, you can't be enrolled until the Group's next open enrollment period. An open enrollment period occurs once a year unless 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 Group offers multiple health care plans and you're enrolled under one of the Group's other health care plans, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

When you enroll for coverage under a different group health care program also offered by the Group, enrollment for coverage under this program can only be made during the Group's open enrollment period.

After an employee's initial enrollment, benefit plan changes can only be made during the open enrollment periods, except under special circumstances. There are two categories of circumstances, which will allow for enrollment changes: IRS Qualifying Events and Special Enrollment Periods.

IRS Qualifying Events allow an employee to make changes to benefit elections outside of the initial enrollment and open enrollment periods. To be eligible to make these changes, an employee must complete and submit the "Fringe Benefit Program – Change in Family Status" form, attaching necessary documentation and enrollment forms <u>within 30 calendar days of the change in status.</u> The documentation should reflect that one of the following IRS Qualifying Events has been met:

- Marriage, divorce or legal separation of the employee;
- Death of the employee's spouse or dependent;
- Birth, adoption, or placement of a child for adoption with the employee (benefit change can be made within 60 days of the change in status for these circumstances only);
- A qualified domestic relations order or qualified medical child support order requiring benefit coverage for the child;
- Termination or commencement of employment of the employee's spouse;
- Employee or spouse changing from part-time and full-time employment status or a significant change in the number of employment hours. The change in hours must be equivalent to at least 20% change in employer's contribution towards insurance;
- Employee or employee's spouse taking a Family Leave Act leave of absence;
- Employee or employee's spouse taking an unpaid leave of absence; and
- A significant change in health coverage of the employee or the employee's spouse attributable to the spouse's employment

Special Enrollment Periods were recently established by federal law and may overlap the IRS Qualifying Events and, like IRS Qualifying Events, will allow an employee to make changes to benefit elections outside the initial enrollment and open enrollment periods:

- An eligible subscriber and any eligible dependents who do not enroll when they are first eligible may choose to enroll at the same time a newly acquired dependent is enrolled. The conditions for enrolling and the effective dates of

coverage will be the same as those stated above in "Adding Dependents after the Subscriber's Effective Date".

- Loss of other coverage. You and your eligible dependents may elect to enroll on this Plan when you lose coverage under another group plan provided:

  Your coverage under the other group plan was terminated as a result of:

  - Loss of eligibility for that coverage
  - Termination of employer contributions toward that coverage
  - The coverage was under COBRA continuation and that coverage has been exhausted

The effective date of coverage for a dependent may not be before the effective date of coverage for the subscriber.

As with any enrollment situation, the acceptance and approval of the changes made by an employee are subject to the terms and conditions of the contract.

CHANGES IN COVERAGE

No rights are vested under this plan. The Group may change its terms, benefits and limitations at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

PLAN TRANSFERS

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

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

- Benefit maximums
- Annual plan maximum
- Coinsurance maximum
- Calendar year deductible.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

Coverage will end without notice on the last day of the month in which one of these events occurs:

- For the subscriber and dependents when:
  - The next required monthly charge for coverage isn't paid when due or within the grace period
  - The subscriber dies or is otherwise no longer eligible as a subscriber
- For a spouse when 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 Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

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

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age (shown under "Dependent Eligibility") for an unmarried 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 the Group with a Request for Certification of Handicapped Dependent form. The Group must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when

requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

LEAVE OF ABSENCE

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 Group to keep coverage in effect for up to 6 months in the event of suspension of compensation due to a lockout, strike, or other labor dispute.

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

COBRA

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

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

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

Qualifying Events And Length Of Coverage

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

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

  However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.
- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
  - **The subscriber dies.**
  - **The subscriber and spouse legally separate or divorce.**
  - **The subscriber becomes entitled to Medicare.**
  - **A child loses eligibility for dependent coverage.**

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

Conditions Of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

The subscriber or affected dependent must notify the Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in "Qualifying Events and Lengths Of Coverage." The subscriber or affected dependent must also notify the Group if the Social Security Administration determines that the

subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Group this notice for you.

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

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

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

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

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

If the Group itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Group must furnish the notice required because of a subscriber's termination of employment, reduction in hours, death 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 after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Please contact the Group or your bargaining representative for more information if you believe this may apply to you.

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

Adding Family Members

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

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

- The applicable continuation period expires.
- The next monthly payment isn't paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see "Qualifying Events and 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 Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.
- You become covered under another group health care plan after the date you elect COBRA coverage.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group health care coverage to any employee.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Group. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA 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 Group 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 payment and completed application to the Group by the due date determined by the Group. Subsequent payments must be paid to the Group, by the date determined by the Group.

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 any required payments for it have been paid when the next monthly payment isn't paid when due or within the grace period.

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

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.

MEDICARE SUPPLEMENT COVERAGE

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

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

Step 1

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

Step 2

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

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or ICD-9 code
- Procedure codes (CPT-4, HCPCS, ADA or UB-92) 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:

Participating 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-Participating 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 participating 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, nor will the plan provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

Special Notice About Claims Procedure

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

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

- A description of the plan's complaint and appeal processes

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

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

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

COMPLAINTS AND APPEALS

When You Have Questions

Call your provider of care when you have questions about the health care services you receive. Please call our Customer Service department with any other questions regarding the plan.

When You Have A Complaint

A **complaint** is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but don't require, that you take advantage of this process when you're not content with a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, a representative will tell you.

When you have a complaint, call or write our Customer Service department. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We also may request more information when needed. When we receive all needed information, we'll review your complaint and respond as soon as possible, but never more than 30 calendar days.

When You Have An Appeal

This plan, the Group and Premera Blue Cross will comply with any new requirements as necessary under the Affordable Care Act and its governing regulations.

An **appeal** is an oral or a written request to reconsider 1) a decision on a complaint, or 2) a decision to deny, modify, reduce, or end payment, coverage or authorization of coverage. This includes admissions to and continued stays in a facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. Please send all appeals, in writing, to the address shown on the back cover of this booklet. We'll let you know when we receive your appeal.

You have the right to give us comments, documents or other information to support your appeal.

Appeals Process

Please call Customer Service if you have questions or need more information about the appeal process. The numbers are shown on the back cover of this booklet.

The plan's standard appeals process has 2 levels of review. Appeal decisions are provided in writing.

Level I The Level I Appeal panel will include health care providers as needed. Persons involved in the initial decision will not be on the panel. The panel give you a written decision within 30 calendar days, with 2 exceptions:

- Urgent appeals (see "Urgent Appeals" below)
- You're appealing a benefit determination that was made prior to you receiving services: We'll decide these appeals no more than 15 days of the date we received them.

If you don't agree with the decision reached in our Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. **You must make your request for a Level II review no more than 60 calendar days after the date you receive our Level I decision.** This time limit may be extended in the event the member needs to obtain additional medical documentation, physician consultations or opinions, if the member is hospitalized or traveling, or for other reasonable cause beyond the member's control. In no case shall the extension exceed 180 days.

Level II Level II appeal decisions will be given to you within 30 calendar days after we receive your level II request, with 2 exceptions noted below:

- Urgent appeals (see "Urgent Appeals" below)
- You're appealing a benefit determination that was made prior to you receiving services: We'll decide these appeals no more than 15 days of the date we received them..

Urgent appeals We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and Level II responses on urgent appeals will be given within 72 hours after the fully documented appeal is received.

If you're appealing a decision to deny, change, reduce or end payment, coverage or authorization of

coverage, and you're not satisfied with the outcome of the Level II appeal, you may ask for an independent review (please see the "Independent Review" provision below). You may also ask for an independent review if we don't give you the Level II decision within the time limit stated. We must receive your request for independent review within 60 calendar days of the date that the appeal decision was due.

Independent Review Independent reviews are conducted by an independent review organization (IRO), which is an organization of medical experts qualified to review your appeal. We'll use IROs that have been certified by the state Department of Health. We'll submit your file to the IRO on your behalf, and you don't have to pay the charges of the IRO. The IRO will give you its decision in writing. We'll implement the IRO's determination promptly.

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Evidence Of Medical Necessity

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

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, the plan is entitled to recover these amounts. 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, as directed by the Group:

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

Member Cooperation

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

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, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with the Group

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

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

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

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

Notice Of Other Coverage

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

- Any legal action or claim against another party for a condition or injury for which the plan provides

benefits; and the name and address of that party's insurance carrier

- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

Notices

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

Right Of Recovery

On behalf of the plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of 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.

Right To And Payment Of Benefits

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

At our option only, we have the right to direct the benefits of this plan to:

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

Payment to any of the above satisfies the plan's obligation as to payment of benefits.

Venue

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

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

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

DEFINITIONS

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

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 unless otherwise specified in the Group's administrative services agreement with us. The allowable charge is described below.

- **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 Washington and Alaska Who Have Agreements With Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside Washington and Alaska, or in Clark County, Washington, allowable charges are determined as stated in the "What Do I Do If I'm Outside Washington And Alaska?" section ("The BlueCard Program") in this booklet.

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

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

An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us

125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available

The provider's billed charges

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 we pay for dialysis during Medicare's waiting period will be no less than a comparable provider that has a contracting agreement with us or another Blue Cross Blue Shield Licensee and no more than 90% of billed charges.

The amount we pay for dialysis after Medicare's waiting period is 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 Services**

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

  - The median amount that Global 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, copayments and coinsurance, you will be responsible for charges received from non-network providers above the allowable charge.

  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.

Complication Of Pregnancy

A condition which falls into one of the 3 categories listed below that requires covered, medically necessary services which are provided in addition to, and greater than, those usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition.

- Diseases of the mother which are not caused by pregnancy, but which coexist with and are adversely affected by pregnancy
- Maternal conditions caused by the pregnancy which make its treatment more difficult. These conditions are limited to:
  - Ectopic pregnancy

- Hydatidiform mole/molar pregnancy
- Incompetent cervix requiring treatment
- Complications of administration of anesthesia or sedation during labor or delivery
- Obstetrical trauma uterine rupture before onset or during labor
- Ante- or postpartum hemorrhage requiring medical/surgical treatment
- Placental conditions which require surgical intervention
- Preterm labor and monitoring
- Toxemia
- Gestational diabetes
- Hyperemesis gravidarum
- Spontaneous miscarriage or missed abortion
- Fetal conditions requiring in utero surgical intervention

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.

Custodial Care

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

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

Detoxification

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

Effective Date

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

Eligibility Waiting Period

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

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 as determined by us:

- 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.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards set in the definition of "Oncology Clinical Trials" below in this section will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

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

Group

The entity that sponsors this self-funded plan.

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

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

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.

Obstetrical Care

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

Voluntary termination of pregnancy is included as part of obstetrical care.

Oncology Clinical Trials

Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An "oncology clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
- Any drug or device provided as part of a phase I oncology clinical trial

- Services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage.
- Services provided in a clinical trial that are fully funded by another source

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage **before** you enroll in the clinical trial.

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 Pharmacy (Participating Retail/Participating Mail-Order Pharmacy)

A licensed pharmacy which contracts with us or our Pharmacy Benefits Administrator to provide prescription drug benefits.

Pharmacy Benefits Administrator

An entity that contracts with us to administer prescription drug benefits under this plan.

Physician

A state-licensed:

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

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

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

Plan (also called "This Plan")

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

Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, 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 health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such

licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

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

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.

Skilled Care

Care that's ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

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

Subscriber

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

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.

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 14711
Lexington, KY 40512

Contact the Pharmacy Benefit Administrator 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
3900 East Sprague
Spokane, WA 99202-4895

Phone Numbers
Local and toll-free number:
1-800-722-1471

Local and toll-free TDD number
for the hearing impaired:
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

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