Unified Insurance Program

uip-wa.org

Vision Plan*

100000030

PREMERA BLUE CROSS

INTRODUCTION

*This booklet is for members of the CWPU Unified Insurance Program Trust medical plan. This plan is self-funded by CWPU Unified Insurance Program Trust, which means that CWPU Unified Insurance Program Trust is financially responsible for the payment of plan benefits. CWPU Unified Insurance Program Trust ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

CWPU Unified Insurance Program Trust 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. CWPU Unified Insurance Program Trust delegated to Premera Blue Cross 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 does not insure the benefits of 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 network providers will cut your costs
- **What Types Of Expenses Am I Responsible For Paying?**
- **What Are My Vision Benefits?** — what's covered and what you need to pay for covered services.
- **Exclusions and Limitations** — 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 website to:

- Locate a vision care provider near you
- Get details about the types of expenses you're responsible for and this plan's benefit maximums
- Check the status of your claims

Group Name:	CWPU Unified Insurance Program Trust
Effective Date:	January 1, 2024
Group Number:	100000030
Plan:	Vision Plan
Certificate Form Number:	CWPUV24

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው፡ 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

TABLE OF CONTENTS

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

Your Identification Card

When you go to your vision care provider, present your Premera Blue Cross identification card.

Selecting a Provider

You have choices of who you will see for your vision care services. This plan gives you access to a network of vision care providers (see ***Definitions***), which includes ophthalmologists, optometrists and opticians.

For a list of network providers, please go to www.premera.com, click on *Find a Doctor* at the top of the page and select “Vision” in the network dropdown menu.

Services From an In-Network Vision Care Provider

When you use a provider who has a network vision agreement:

- The provider will bill the plan. Payment for covered services will be sent directly to the provider.
- Network providers provide vision care to members at negotiated fees. These fees are the allowable charges for network providers. You will not be responsible for any charges which exceed the allowable charge for covered services. See ***Definitions*** for more information about the allowable charge.

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

You are still responsible for any expenses incurred in connection with services and supplies not covered by your vision care plan, for any difference between the plan’s benefit maximums and the allowable charge, and for the copayment required for the vision exam.

Network vision care providers are:

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

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

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

Services From a Out-Of-Network Vision Care Provider

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

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

- There are also vision care providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These vision care providers are called "non-contracted" providers in this booklet. "Non-contracted" providers have the right to charge you more than the allowable charge for a covered service. You may also be required to submit the claim yourself. See ***How Do I File A Claim?*** for details.
- Covered services from vision care providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands are always reimbursed at the in-network level of benefits.

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

COPAYMENTS

Copayments (hereafter referred to as "copays") are fixed up-front dollar amounts that you're required to pay for covered vision exams. Your vision care provider may ask that you pay the copay at the time of service.

The copay amount is located under the ***What Are My Vision Benefits?*** section later in this booklet.

COINSURANCE

"Coinsurance" is a defined percentage of allowable charges for covered vision exams. It's the percentage you're responsible for, not including copays, when the plan provides benefits at less than 100% of the allowable charge.

The coinsurance percentage is in ***What Are My Vision Benefits?*** section.

WHAT ARE MY VISION BENEFITS?

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

- It must be medically necessary (see the ***Definitions*** section in this booklet)
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan, except as stated under the Vision Hardware benefit.
- It must be furnished by a "vision care provider" (see the ***Definitions*** section in this booklet) who's performing services within the scope of their license or certification.

Benefits for some types of services and supplies may be limited or excluded under this plan. Refer to the actual benefit provisions and the ***Exclusions and Limitations*** section for a complete description of covered services and supplies, limitations and exclusions.

VISION EXAMS

You pay a $25 copay per exam when you use a network provider. If vision testing is done during the same visit as the routine vision exam, you will pay only one copay.

Note: When you use a non-network provider, you pay both a $25 copay and coinsurance of 30% of allowed charges.

Covered Services

This benefit provides for 1 routine vision exam per member each calendar year. 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

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

VISION HARDWARE

Benefits for vision hardware are provided when all of the requirements listed below are met:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be named in this benefit as covered
- They must not be excluded from coverage under this plan

Benefits for the following vision hardware and related services are provided at 100% of allowable charges, up to a maximum benefit of $200 per member every 2 consecutive calendar years, resetting on each odd calendar year.

What's Covered:

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for prescription eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses, to include lenses and frames
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Vision hardware benefits are based on the "allowable charge" (see the ***Definitions*** section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit aren't covered.

Important Note! If you also have coverage under a medical plan sponsored by the Group, prescribed vision hardware necessitated by surgery, injury or disease is covered under the medical plan.

The Vision Hardware benefit doesn't cover:

- Services or supplies that aren't named above as covered.
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Non-prescription sunglasses lenses and/or frames
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
  - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

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

OUT-OF-AREA CARE

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

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

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

BlueCard Program

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

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

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

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

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

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

Taxes, Surcharges and Fees

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

Non-Contracted Providers

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

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

Blue Cross Blue Shield Global® Core

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

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

More Questions

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

EXCLUSIONS AND LIMITATIONS

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

Amounts That Exceed The Allowed Amount

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

Benefits from other sources

Services that are covered by liability insurance, motor vehicle insurance, excess coverage, no fault coverage or workers compensation or similar coverage for work-related conditions. For details, see ***Third Party Recovery*** under ***What If I Have Other Coverage***.

Benefits that have been exhausted

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

Broken or missed appointments

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

Charges For Records or Reports

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

Court-Ordered Services

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

Drugs or Medications

Benefits are not provided under this plan for drugs or medications, including prescription or over-the counter drugs, solutions, supplies, food and nutritional supplements, herbal, naturopathic, or homeopathic medicines or devices, or vitamins.

Experimental or Investigational Services

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

Family Members or Volunteers

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

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

Governmental Facilities

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

Illegal Acts, Illegal Services, and Terrorism

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

Medical Treatment of Eye Conditions

Benefits are not provided for diagnostic or treatment, including surgery or other therapeutic treatment of eye conditions, including medical complications. The exceptions are glaucoma or other testing provided in conjunction with refractive eye exams.

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country, including any related civilian forces or units.

Non-Covered Services

Services or supplies directly related to any non-covered condition.

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

Provider's Licensing or Certification

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

Services or Supplies Not Medically Necessary

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

Vision Therapy

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

Work-Related Illness or Injury

Any illness, condition or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see ***Third Party Recovery*** under ***What's If I Have Other Coverage***.

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 plans aren't more than the total allowable expenses.

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

Each contract or other arrangement for coverage described above is a separate plan.

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 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. If the parent who is responsible has no health coverage for the dependent, but that parent's spouse does, that spouse's plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.
  - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
  - If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
  - If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.

- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
  - The plan covering the custodial parent, first
  - The plan covering the spouse of the custodial parent, second
  - The plan covering the non-custodial parent, third
  - The plan covering the spouse of the non-custodial parent, last
  - If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

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

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

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

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

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

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 expenses or allowable expenses not otherwise paid, and such reduced amount shall be charged against the applicable plan's benefit limit (medical). 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 expenses or allowable 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.

THIRD PARTY RECOVERY

General

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

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

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

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

Definitions

The following definitions shall apply to this section:

Injury An injury or illness that a third party is or may be liable for.

Recovery All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgment, award, or settlement. It does not matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amounts put into a trust or constructive trust set up by or for you or your family, beneficiaries or estate as a result of your injury.

Reimbursement Amount The amount of benefits paid by the plan for your injury and that you must pay back to the plan out of any recovery per the terms of this section.

Responsible Third Party A third party that is or may be responsible under the law (“liable”) to pay you back for your injury.

Third Party A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers’ compensation coverage. The third party may not be the actual party who caused the injury, and may include an insurer.

Note: For this section, a third party does not include other health care plans that cover you.

You In this section, “you” includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

- **Benefits From Other Sources** Benefits are not available under this plan when coverage is available through:
  - Motor vehicle medical or motor vehicle no-fault
  - Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage, or Medical Premises coverage
  - Boat coverage
  - School or athletic coverage
  - Any type of liability insurance, such as home owners' coverage or commercial liability coverage
  - Any type of excess coverage
- **Work-Related Illness Or Injury**

  This plan does not cover any illness, condition or injury, for which you get benefits under:
  - Separate coverage for illness or injury on the job
  - Workers’ compensation laws
  - Any other law that would pay you for an illness or injury you get on the job.

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

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost sharing required by motor vehicle coverage, unless applicable state law requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits.

- The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer or your estate.
  - The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.
- The plan's right to reimbursement first and in full shall apply even if:
  - The recovery is not enough to make you whole for your injury.
  - The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
  - The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
  - The member is a minor, disabled person, or is not able to understand or make decisions.
  - The member did not make a claim for medical expenses as part of any claim or demand
- Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.

  The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third-party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

- If any of the requirements below are not met, the plan shall:
  - Deny or delay claims related to your injury
  - Recoup directly from you all benefits the plan has provided for your injury
  - Deduct the benefits owed from any future claims
- You must notify Premera Blue Cross of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information.

  Neither the plan nor Premera Blue Cross shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

  Claims for your injury shall not be paid until Premera Blue Cross receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

If you receive a recovery, you or your lawyer shall hold the Recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the plan's reimbursement rights have been determined, you shall make immediate payment to the plan out of the recovery proceeds.

If you or your lawyer do not promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to one or both of the following:

- Initiating an action against you and/or your lawyer to compel compliance with this section.

Withholding plan benefits payable to you or your family until you and your lawyer complies or until the reimbursement amount has been fully paid to the plan.

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage.

The acceptance and approval of any changes made by an employee are subject to the terms and conditions of the contract.

SUBSCRIBER ELIGIBILITY

To be an eligible subscriber under this plan, you must:

- Be a duly elected Commissioner, or
- Be a regular and active employee who is paid on a regular basis through the Group's payroll system, and reported by the Group for Social Security purposes and works a minimum of 40 hours per week, or
- Be employed as a regularly scheduled part-time employee as defined by the Utility

Employees Performing Employment Services In Hawaii

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

DEPENDENT ELIGIBILITY

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

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

  All rights, benefits and obligations afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible dependent child who is under 26 years of age, except as provided for in the ***How Do I Continue Coverage? Continued Eligibility for a Disabled Child*** provision.

  An eligible child is one of the following:
  - A natural offspring of either or both the subscriber or spouse
  - A legally adopted child of either or both the subscriber or spouse
  - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
  - A dependent child age 26 or older incapable of self-support due to a developmental or physical disability that occurred before age 26 may be an eligible dependent when the child is chiefly dependent upon the

subscriber for support and maintenance. A Request for Certification of Handicapped Dependent form must be completed and submitted through the group. The group must approve the request for certification before coverage can become effective.

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

Please contact your Group's Human Resources (HR) department regarding subscriber/dependent enrollment procedures and documentation requirements.

WHEN DOES COVERAGE BEGIN?

INITIAL ENROLLMENT

Enrollment for subscribers (except elected Commissioners) is mandatory. Coverage is effective on the date the subscriber (employee) becomes eligible for benefits coverage.

Enrollment for dependents is optional. To enroll dependents timely, the completed enrollment application, documentation that substantiates dependent eligibility (as applicable) and required subscription charges must be received within 30 days of the date the employee becomes an "eligible employee" as defined in the ***Who Is Eligible For Coverage?*** section. If enrollment is timely, coverage for the enrolled dependents will become effective on the date the subscriber becomes eligible for benefits.

If the requirements stated above are not met, the dependent(s) will not be enrolled for benefits coverage. See the ***Special Enrollment*** and ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions.

Dependents Through Marriage After The Subscriber's Effective Date

If the completed enrollment application, documentation that substantiates dependent eligibility and any required subscription charges are received within 30 days after the marriage, coverage will become effective on the date of marriage. If such requirements are not met, the dependent(s) will not be enrolled for benefits coverage. See the ***Special Enrollment*** and ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions.

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

- Coverage becomes effective for natural newborn children on the date of birth.
- **A completed enrollment application, documentation that substantiates dependent eligibility** and any required subscription charges **must be received by us within 60 days following birth**. If such requirements are met, coverage becomes effective from the date of birth. If such requirements are not met, the dependent(s) will not be enrolled for benefits coverage. See the ***Special Enrollment*** and ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions."

Adoptive Children On Or After The Subscriber's Effective Date

- A completed enrollment application, documentation that substantiates dependent eligibility and any required subscription charges must be received within 60 days following the date of placement with the subscriber. If these requirements are met, coverage becomes effective from the date of placement. If such requirements are not met, the dependent(s) will not be enrolled for benefits coverage. See the ***Special Enrollment*** and ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions.

Foster Children

To enroll a new foster child, a completed enrollment form, a copy of the child's foster papers and any required subscription charges **must be received by us within 60 days** after the date the subscriber became the child's foster parent. If such requirements are met, coverage becomes effective from the date the subscriber became the child's foster parent. If such requirements are not met, the dependent(s) will not be enrolled for benefits coverage. See the ***Special Enrollment*** and ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions."

Children Through Legal Guardianship

If the completed enrollment application, documentation that substantiates dependent eligibility and any required subscription charges are received 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 such requirements are not met, the dependent(s) will not be enrolled for benefits coverage. See the ***Special Enrollment*** and ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions.

Children Covered Under Medical Child Support Orders

If the completed enrollment application and accompanying support order are received 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 the documentation referenced above is received. The enrollment application and support order may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid or the state child support enforcement agency. Any required subscription charges for such dependent children will begin on the child's effective date of coverage.

SPECIAL ENROLLMENT

Special Enrollment Periods

Note that there are specific “special enrollment” rights, which allow the employee (and eligible dependents) to either:

- Enroll in the employee’s current medical coverage option; or
- Enroll in any medical plan benefit option for which the employee and dependents are eligible.

Such “special enrollment” events (listed below), allows dependents to be enrolled outside the plan's annual open enrollment period. In order to be enrolled, the applicant will be required to provide proof (documentation) of special enrollment rights and dependent eligibility. If a completed enrollment application and all supporting documentation is not received within the time limits stated below, further chances to enroll depend on the normal rules of the plan that govern late enrollment. See the ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions.

Except as stated otherwise below, an eligible dependent’s coverage will begin on the actual date of the qualifying event (i.e. date of marriage, date of adoption, date of custody decree, etc.).

Involuntary Loss of Other Coverage

Enrollment for subscribers (except elected Commissioners) is mandatory. However, if an otherwise eligible dependent doesn't enroll in this plan or another plan sponsored by the Group when first eligible, that dependent may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

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

When an eligible dependent qualifies for special enrollment, the eligible subscriber (employee) is also allowed to change plan options at the same time the dependent is enrolled.

The completed enrollment application, documentation that substantiates dependent eligibility and any required subscription charges must be received 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. However, if enrollment/documentation requirements are not met, the dependent(s) will not be enrolled for benefits

coverage. See the ***Dependent Special Enrollment*** and ***Open Enrollment/Change in Family Status*** provisions later in this section for information on enrolling dependents under alternate provisions.

Dependent Special Enrollment

An eligible dependent who was not previously enrolled 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.

State Medical Assistance and Children's Health Insurance Program

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 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 completed enrollment application, documentation that substantiates dependent eligibility and any required subscription charges must be submitted within 60 days from the date one of the applicable statements above is true. Coverage will be effective on the first day of the month following the date one of the statements described in this section (above) is applicable. If the enrollment/documentation requirements are not met, the dependent(s) will not be enrolled for benefits coverage. See the ***Open Enrollment/Change in Family Status*** provision below.

OPEN ENROLLMENT/ CHANGE IN FAMILY STATUS

If a dependent is not enrolled when they first become eligible, or as allowed under ***Special Enrollment*** above, they can't be enrolled until the Group's next "open enrollment" period. During this period, eligible dependents can enroll for coverage under this program.

Transferring enrollment between different group healthcare options offered by the Group is only allowed during the Open Enrollment period, except as described above (***Involuntary Loss of Other Coverage***).

After an employee's initial enrollment, benefit plan changes outside of Open Enrollment can only be made under special circumstances. There are two categories of circumstances, which will allow for benefit plan enrollment changes:

- Special Enrollment Periods (see above)
- IRS Qualifying Events

IRS Qualifying Events

IRS qualifying status change events permit an employee to create a new election, revoke an existing election, or add/drop dependents so long as that election change is consistent with the status change event. The only events that permit a change in benefit option are those events that are also special enrollment events as listed above.

To be eligible to make these changes, an employee must complete an updated enrollment form and submit all required supporting documentation within 30 calendar days of the change in status (unless otherwise indicated below). If enrollment/documentation requirements are not met, changes will not occur until such later time as ***Open Enrollment*** or other ***Special Enrollment*** provisions become applicable. The documentation must reflect that one of the following IRS Qualifying Events has been met (and that the requested election change is consistent with the event) and must substantiate dependent eligibility, as referenced previously:

- Marriage (also allows for a benefit option change as described under “special enrollment” rights)
- 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 (also allows for a benefit option change as described under “special enrollment” rights and must be made within 60 days of the change in status)
- 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 the employer's contribution towards insurance
- Employee or employee's spouse taking a Family Leave Act leave of absence
- A significant change in health coverage of the employee or the employee's spouse attributable to the spouse's employment

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

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.

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

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by the 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 under the prior plan:

- Benefit maximums

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when:
  - The 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 their marriage to the subscriber is annulled, or when they become legally separated or divorced from the subscriber
- For a child when they cannot meet the requirements for dependent coverage shown 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. Failure by the subscriber to provide timely notification may result in the subscriber being liable for claims and premiums paid by the employer for ineligible dependents.

PLAN TERMINATION

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 a dependent child who can't support themselves because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching the limiting age

- The child is incapable of self-sustaining employment by reason of developmental or physical disability and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes the Group with a Request for Certification of Disabled 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

Family and Medical Leave Act

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

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

The subscriber must pay their normal share of the subscription charges during the leave.

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

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

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

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

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

Paid Family and Medical Leave Act (PFML)

For additional information regarding PFML, please contact your Human Resources department.

Other Leaves of Absence

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by state or other federal laws, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid. The requirements and the length of leave may vary. Please contact the Group for details.

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.

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

- 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 Length 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. **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 Length 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 Length~~s~~ 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 federal laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

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 866-4-USA-DOL or visit its website at www.dol.gov/vets. An online guide to USERRA can be viewed at webapps.dol.gov/elaws/vets/userra/.

HOW DO I FILE A CLAIM?

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 diagnosis code from the most current edition of the **International Classification of Diseases** manual.
- Procedure codes from the most current edition of the **Current Procedural Terminology** manual, the **Healthcare Common Procedure Coding** manual
- 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.

Timely Filing

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

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

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

COMPLAINTS AND APPEALS

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

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

What is a Complaint?

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

How to file a complaint

Call customer service at 800-722-1471 (TTY:711)

Send a fax to 425-918-5592

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

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

What is an Appeal?

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

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

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

WHAT YOU CAN APPEAL

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

APPEAL LEVELS

You have the right to two levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2 (Internal)	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified of our Level 1 appeal decision.

External	If we deny your Level 2 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	Four months from the date you were notified of our Level 2 appeal decision. OR Four months from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.

How to Submit an Appeal in Writing

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on premera.com or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-722-1471 (TTY:711)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on premera.com. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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

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

Premera Blue Cross

Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111

Fax: 425-918-5592

Appeal Response Time Limits

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

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 15 days
All other appeals	15-30 days
External appeals	Urgent appeals within 72 hours Other IRO appeals within 45 days after the IRO gets the information

IF WE NEED MORE TIME

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

WHAT IF YOU HAVE ONGOING CARE

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

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

WHAT IF IT'S URGENT

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

Examples of urgent situations are:

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

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

HOW TO ASK FOR AN EXTERNAL REVIEW

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

Step 1. **Get the form**	**We'll tell you about your right to an external review with the written decision of your internal appeal.** • Complete the Independent Review Organization (IRO) Request form, you can find it on premera.com or call customer service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.

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

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

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

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and Premera immediately. Premera will accept the IRO decision on behalf of the plan.

If the IRO:

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

If you have questions about a denial of a claim or your appeal rights, you may call customer service at the number listed on your Premera ID card.

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.

Health Care Providers — Independent Contractors

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

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, the plan is entitled to recover these amounts. 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
- Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all)

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

Member Cooperation

You're under a duty to cooperate with us 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 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 their dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

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.

Accidental Injury

Physical harm caused by a sudden, unexpected event at a certain time and place. Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

Adverse Benefit Determination

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

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

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.

General Rules

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

  For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us

when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

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

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

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

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

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

  - An amount that is no less than the lowest amount 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 as implemented by Premera
  - The provider's billed charges. Note: Ambulances are always paid based on billed charges.

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

If you have questions about this information, please call us at the number listed on your Central Washington Public Utilities ID card.

Benefit

What this plan provides for a covered service. The benefits you get are subject to this plan's cost shares.

Benefit Booklet

Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.

Calendar Year

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

Cost share

The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.

Covered Service

A service, supply or drug that is eligible for benefits under the terms of this Plan.

Effective Date

The date when your coverage under this plan begins.

Eligibility Waiting Period

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

Experimental/Investigative Services

A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board.
- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Explanation of Benefits

An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.

Group

The entity that sponsors this self-funded plan.

In-Network Vision Care Provider

A vision care provider (see below in this section) that, at the time services were rendered, has an agreement in effect with Premera Blue Cross to furnish vision services to members.

Lifetime Maximum

The maximum amount that your insurance benefit will provide during your lifetime.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.

Medically Necessary and Medical Necessity

Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must:

- Agree with generally accepted standards of medical practice;
- Be clinically appropriate, in terms of type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease.
- Not be mostly for the convenience of the patient, physician, or other health care provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" and "Your")

A person covered under this plan as a subscriber or dependent.

Non-Contracted Vision Care Provider

A vision care provider that is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield Licensee.

Out-Of-Network Vision Care Provider

A vision care provider (licensed ophthalmologist, optometrist or optician) that, at the time services were rendered, does not have an agreement in effect with Premera Blue Cross to furnish vision services to members.

Note: When you receive services from a non-contracting provider, you will be responsible for paying any difference between the allowed amount and the provider's billed charge.

Plan (also called "This Plan")

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

Prior Authorization

Prior authorization is a process that requires you or a provider to follow before a service is given, to determine if service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness. You must ask for prior authorization before the service is delivered.

Service Area

The area in which we directly operate provider networks. This area is made up of the states of Washington (except Clark County) and Alaska.

Spouse

Someone who is legally married to the subscriber. A spouse can also be the subscriber's domestic partner.

Subscriber

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

Subscription Charges

The monthly rates to be paid by the member that are set by the Group as a condition of the member's coverage under the plan.

Vision Care Provider

A vision care practitioner who is licensed as an ophthalmologist, optometrist or optician to practice health care related services consistent with state law, and that practices within the scope of such licensure or certification.

Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of their employment.

- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

We, Us and Our

Premera Blue Cross.

Where To Send Claims

MAIL YOUR CLAIMS TO

Premera Blue Cross
PO Box 327
Seattle, WA 98111-0327

Customer Service

Mailing Address
Premera Blue Cross
PO Box 327
Seattle, WA 981110327

Physical Address
3900 East Sprague
Spokane, WA 99202-4895

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

Local and toll-free TTY number:
711

Complaints And Appeals

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

Website

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