QHDHP

WEA Select Qualified High Deductible Health Plan (QHDHP)

Plan effective November 1, 2015

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

WEA WASHINGTON EDUCATION ASSOCIATION SELECT

premera.com/wea

Customer Service

PREMERA BLUE CROSS

Customer Service

Contact Premera Customer Service for help with:

- Benefits
- Claims

800-932-9221
TTY 800-842-5357

premera.com/wea

Mailing Address

Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

Appeals Mailing Address

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

Fax 425-918-5592

Physical Address

Premera Blue Cross
7001 220th St. SW
Mountlake Terrace, WA 98043-2124

Visit **premera.com/wea** for:

- Forms
- Benefit booklet and summaries
- Provider directory
- Pharmacy information
- Claims status and online Explanation of Benefits
- Resources for researching health topics
- Enrollee discounts

AON HEWITT

Your Benefits Resources™ WEA Select Benefits Center

Contact the WEA Select Benefits Center for help with:

- Eligibility
- Enrollment

855-668-5039

http://resources.hewitt.com/wea

Express Scripts Home Delivery

Mail-order pharmacy

800-626-6080 or

premera.com/wea

Express Scripts Home Delivery is an independent company that provides mail-order pharmacy services on behalf of Premera Blue Cross.

BlueCard® Program

Out-of-state network providers

800-810-2583 or

premera.com/wea

WASHINGTON EDUCATION ASSOCIATION
SELECT QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP) (FOUNDATION)

HOW TO CONTACT US (INSIDE FRONT COVER)

SUMMARY OF YOUR COSTS 5

INTRODUCTION 9

WEA Claim Review 9

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS? 11

HOW DO I SUBMIT A CLAIM? 13

WHAT DO I DO IF I'M OUTSIDE WASHINGTON AND ALASKA? 14

The BlueCard® Program (out-of-area services) And Other Inter-Plan Arrangements 14

WHAT IS THE ROLE OF INTEGRATED HEALTH MANAGEMENT AND CASE MANAGEMENT? 16

Prior Authorization 16

Clinical Review 18

Case Management 18

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING? 18

Calendar Year Deductible 18

Coinsurance 19

Out-Of-Pocket Maximum 19

WHAT ARE MY BENEFITS? 19

Acupuncture Services 19

Ambulance Services 19

Blood and Blood Products 19

Chemical Dependency/Behavioral Health Treatment (Inpatient and Outpatient) 20

Clinical Trials 21

Contraceptive Services 21

Dental Services 22

Diagnostic Imaging and Laboratory Services 22

Dialysis 22

Emergency Room Services 23

Health Management 23

Home Health Care 23

Hospice Care 25

Hospital Services (Inpatient and Outpatient) 25

Infusion Therapy 26
Mastectomy And Breast Reconstruction 26
Medical Foods 27
Mental Health Care/Behavioral Health (Inpatient and Outpatient) 27
Neurodevelopmental Therapy (Inpatient and Outpatient) 29
Newborn Care 30
Nutritional Therapy 31
Obstetrical (Maternity) Care 31
Office Visits (Office and Home) 31
Prescription Drugs 32
Preventive Care 36
Preventive Screenings 37
Prosthetics, Orthotics and Medical Equipment 37
Psychological and Neuropsychological Testing 39
Rehabilitative Care (Inpatient and Outpatient) 39
Skilled Nursing Facility 40
Spinal Manipulations and Associated Services 41
Surgical And Medical Care (Professional) 41
Temporomandibular Joint (TMJ) Disorders 42
Transgender Services 42
Transplants 43
Vision Therapy 44
WHAT'S NOT COVERED? 45
Non-Covered Services 45
Limited Services 45
GENERAL PROVISIONS 48
Certification Of Need For Health Care Services 48
Notice Of Information Use And Disclosure 48
Transfer Of Benefits: Assignment, Garnishment And Attachment 48
Right Of Recovery 49
Fraudulent Claims 49
Venue 49
Notice Of Other Coverage 49
WHAT IF I HAVE OTHER COVERAGE? 49
Coordinating Benefits With Other Plans (COB) 49
Effect Of Medicare 52

Dual WEA Coverage ... 52
Subrogation And Reimbursement ... 52
Uninsured And Underinsured Motorist/Personal Injury Protection Coverage ... 53
WHO IS ELIGIBLE FOR COVERAGE, AND WHEN? ... 53
Employee Coverage ... 53
Age 65/Continuing Employment As An Active Employee ... 54
Dependent Coverage ... 54
Verifying Dependents ... 54
Marriage ... 55
Natural Newborn Children ... 55
Adoptive Children ... 55
Legal Guardianship/Non-Parental Custody ... 55
Medical Child Support Orders ... 56
Surviving Dependents ... 56
Change In Dependent Status ... 56
Loss Of Other Coverage ... 56
Enrollment Periods ... 56
Open Enrollment ... 57
Special Enrollment ... 57
Medical Assistance And Children's Health Insurance Program ... 57
Continued Enrollment: Self-Pay Provisions ... 57
Leave Of Absence ... 57
Family Medical Leave ... 58
Labor Dispute ... 58
Reduction In Force (for employee groups with less than 20 employees) ... 58
How Do I Continue Coverage? ... 58
Continuation Under USERRA ... 58
COBRA Continuation Of Group Coverage (for participating employee groups with 20 or more employees) ... 59
Converting To A Different Plan ... 61
Individual Coverage ... 62
Medicare Supplement Coverage ... 62
When You Retire ... 62
WHEN WILL MY COVERAGE END? ... 62
Rights To Benefits After Termination ... 62
Events That End Coverage ... 62

Plan Transfers 63
COMPLAINTS AND APPEALS 63
When You Have Ideas 63
When You Have Questions 63
When You Have A Complaint 63
When You Do Not Agree With A Payment Or Benefit Decision 64
When You Have An Appeal 64
When Am I Eligible For External Review? 66
ADDITIONAL INFORMATION ABOUT YOUR COVERAGE 66
DEFINITIONS 67
LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT PLAN 72
INDEX 78

WASHINGTON EDUCATION ASSOCIATION SELECT QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

This is plan uses the following network:

- ***Foundation*** Network

SUMMARY OF YOUR COSTS

This is a summary of your costs for covered services. Your costs are subject to the all of the following.

- The allowable charge. This is the maximum amount Premera Blue Cross will pay for covered services. In-network providers will accept the allowable charge as total payment. Out-of-network providers may bill you for charges over Premera Blue Cross's allowable charge..
- The deductible. The calendar year deductible is the amount you must pay each year before your plan benefits are available to you. It applies to all benefits, except as specified.

Foundation Providers	$1,500 per enrollee and $3,000 per family per calendar year
Non-Foundation Providers	$3,000 per enrollee and $6,000 per family per calendar year

- The coinsurance. This is a percentage of the allowable charge that you must pay for certain services and supplies. Coinsurance does not apply towards the calendar year deductible.
- The out-of-pocket maximum consists of your in-network deductible and coinsurance combined for most covered medical services. This is the most you pay each calendar year for services from in-network providers. Once you have reached the out-of-pocket maximum, covered services will be paid at 100% of the allowable charge for the remainder of the calendar year.

Foundation Providers	$4,000 per enrollee or $8,000 per family per calendar year
Non-Foundation Providers	There is no out-of-pocket maximum for out-of-network providers

The conditions, time limits and maximums are described in this booklet. Some services have special rules. See ***Covered Services*** for these details.

The costs shown below are what you pay after the deductible(s) are met. Sometimes the deductible is waived. This is also shown below. Some services may require prior authorization. Please see “Prior Authorization” on page 16, or call WEA Select Customer Service for more information.

	YOUR COSTS OF THE ALLOWABLE CHARGE	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
COMMON MEDICAL SERVICES		
Office and Clinic Visits You may have additional costs for things such as x-rays and lab. See those covered services for details.		
• Office visits with your physician or provider	20%	50%
• Office visit with your gynecologist (even if not your primary physician)	20%	50%
• Non-hospital urgent care centers and all other non-hospital provider office visits	20%	50%
Preventive Care		
• Exams and immunizations are limited in how often you can get them based on your age and gender	$0, deductible waived	Not Covered
• Seasonal immunizations	$0, deductible waived	$0, deductible waived
• Preventive screenings	$0, deductible waived	50%

	YOUR COSTS OF THE ALLOWABLE CHARGE	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
• Contraceptive services • Health education and tobacco use cessation programs A full list of preventive services is available at www.premera.com/wea, or by contacting WEA Select Customer Service at 1-800-932-9221.	$0, deductible waived $0, deductible waived	50% Not covered
Diagnostic X-ray, Lab and Imaging • Basic diagnostic x-ray, lab and imaging • Major diagnostic x-ray and imaging • Sleep studies (Please contact Customer Service before seeking services)	 20% 20% 20%	 50% 50% 50%
Prescription Drugs– Retail Pharmacy Up to a 30-day supply • Preventive drugs • Generic drugs • Preferred List Brand Name Drugs • Non-Preferred List Brand Name Drugs • Oral chemotherapy drugs	 $0, deductible waived 20% 20% 20% 20%	 20% 20% 20% 20% 20%
Prescription Drugs – Mail-Order Pharmacy Up to a 90-day supply • Preventive drugs • Generic drugs • Preferred List Brand Name Drugs • Non-Preferred List Brand Name Drugs • Oral chemotherapy drugs **Please note:** Non-participating pharmacies are not covered.	 $0, deductible waived 20% 20% 20% 20%	 20% 20% 20% 20% 20%
Prescription Drugs– Specialty Pharmacy Up to a 30-day supply	Same as retail cost-shares	Same as retail cost-shares
Surgical and Medical Care (Professional) Services • Inpatient hospital • Outpatient hospital, ambulatory surgical center • Professional services For additional information on benefits for inpatient and outpatient hospital services, please see the Hospital Inpatient Care and Hospital Outpatient Care benefits.	 20% 20% 20%	 50% 50% 50%

	YOUR COSTS OF THE ALLOWABLE CHARGE	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
Emergency Room		
• Facility	20%	20%
• Professional, diagnostic services, other services and supplies	20%	20%
Please also see Office Visits regarding non-hospital Urgent Care Centers, which may be an appropriate alternative in some situations.		
Ambulance Services (In Washington)	20%	20%
Hospital Services		
• Inpatient Care	20%	50%
• Outpatient Care	20%	50%
For additional information on benefits for inpatient and outpatient hospital services, please see the Hospital Inpatient Care and Hospital Outpatient Care benefits.		
Mental Health and Chemical Dependency		
• Office visits	20%	50%
• Inpatient or partial hospitalization	20%	50%
Maternity and Newborn Care Prenatal, postnatal, delivery, inpatient care and termination of pregnancy		
• Hospital	20%	50%
• Birthing center or short-stay facility	20%	50%
• Diagnostic tests during pregnancy	20%	50%
• Professional	20%	50%
Home Health Care (130 visits per enrollee per calendar year)	20%	50%
Hospice Care		
• Home visits	20%	50%
Please note: You are also covered up to 10 days of inpatient care in a hospice that is Medicare-certified or state licensed or state-certified by the state in which it operates when ordered by the attending physician (M.D. or D.O.).		
• Respite care, inpatient or outpatient (240 hours in each 6 month period)	20%	50%
Rehabilitation Therapy		
• Inpatient (limited to 30 days per calendar year)	20%	50%
• Outpatient (limited to 15 visits per calendar year)	20%	50%
• Psychological and neuropsychological testing	20%	50%

	YOUR COSTS OF THE ALLOWABLE CHARGE	
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
Skilled Nursing Facility and Care (limited to 60 days per calendar year) • Skilled nursing facility care	 20%	 50%
Home Medical Equipment (HME), Supplies, Devices, Prosthetics and Orthotics	20%	50%
OTHER COVERED SERVICES		
Acupuncture Limited to 12 visits per calendar year	20%	50%
Chemotherapy and Radiation Therapy Please also see Oral Chemotherapy under Prescription Drugs.	20%	50%
Dental Accidents	20%	50%
Dental Anesthesia When medically necessary	20%	50%
Infusion Therapy	20%	50%
Mastectomy and Breast Reconstruction	20%	50%
Medical Foods	20%	50%
Spinal or Other Manipulative Treatment (Limited to 12 visits per calendar year)	20%	50%
Temporomandibular Joint (TMJ) Disorders	20%	50%
Transplants • Office visits • Inpatient facility • Other professional services • Travel and lodging subject only to the deductible; $7,500 limit per transplant.	 20% 20% 20% $0	 50% 50% 50% $0

INTRODUCTION

This plan meets the requirements of a high deductible health plan for use with a Health Savings Account. Premera Blue Cross is not an administrator, trustee or fiduciary of any Health Savings Account which may be used in conjunction with this health plan. No feature of this plan is intended to, or should be assumed to, override Health Savings Account requirements. Please contact your Health Savings Account administrator if you have questions about requirements for Health Savings Accounts.

Your WEA Select Medical Plan was designed specifically for school employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Hewitt (Employee Benefits Consultant), Premera Blue Cross (Medical Plan Underwriter) and Underwritten by Unum Life Insurance Company of America (Life Insurance Underwriter).

The WEA is the policyholder for this medical benefits plan. The WEA retains full and exclusive authority, at its discretion, to determine its availability. The plan is not guaranteed to continue indefinitely, and it may be altered or terminated at any time.

The WEA Benefits Services Advisory Board (BSAB) reviews all plan benefits and limitations, and they are approved by the WEA Board of Directors. Your suggestions for plan improvements are always welcome and may be forwarded to the WEA or Aon Hewitt.

WEA CLAIM REVIEW

The WEA Board of Directors or its appointed Benefit Services Advisory Board (BSAB) has the authority under this contract to reconsider claims for benefits which have been denied in whole or in part by Premera Blue Cross and to determine if additional benefits should be provided. This provision will provide a means whereby a claim for benefits can be reconsidered and additional benefits provided to the extent herein specified and to the extent there are WEA funds available to cover such additional benefits. The circumstances under which the appointed BSAB may approve additional benefits when a claim for benefits is denied are outlined in the WEA "Procedure for Benefit Services Claim Review."

If you do not agree with a claim denial made by Premera Blue Cross, you may submit a request for review. The BSAB shall conduct a hearing at which the participant shall be entitled to present his or her opinion and any evidence in support thereof. Thereafter, BSAB shall issue a written decision affirming, modifying or setting aside the former action. For more information on the WEA claim review, you may contact Aon Hewitt at 206-467-4646.

Costs incurred by a claimant in preparing or presenting an appeal to the BSAB, such as attorney's fees, copying or postage charges or travel expenses, must be born by the claimant, and the claimant will be asked to sign a written consent to have the pertinent medical information provided to the BSAB.

UNDERSTANDING YOUR BENEFITS

To understand how your benefits are paid, please review this booklet when you enroll. As you incur medical expenses, you may wish to review the section which applies to them.

WEA Select Customer Service at Premera Blue Cross serves WEA Medical Plan enrollees. Please call one of the following numbers if you have questions on coverage or claims:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

The WEA Select Medical Plans are administered to comply with the requirements of the Patient Protection and Affordable Care Act (PPACA), also known as federal health care reform. Federal and state authorities continue to issue new and revised guidance, including laws and regulations regarding the administration of health plans. If additional laws or regulations are issued, this plan will be administered in accordance with the applicable requirements.

Group Name:..Washington Education Association
Plan Year:...November 1, 2015 – October 31, 2016
Group Number: ....WEA Qualified HDHP (Foundation)
Contract Form Number: 1223WQHDHP

KEEPING COSTS DOWN

We are all aware that health care costs continue to rise and are reflected in our medical rates. We can help control costs by working together. The WEA Select Medical Plan is designed to encourage efficient use of health care services. You can help limit health care cost increases by taking the following simple steps whenever possible:

- When hospital or medical services are necessary, seek care from a network provider.
- Seek medical help in a physician’s office or non-hospital urgent care center rather than a hospital emergency room.
- Receive treatment for simple surgeries, diagnostic and preadmission tests as an outpatient or in the physician’s office.
- Use your prescription drug benefit wisely by substituting generic drugs if your doctor agrees, and using home delivery services for maintenance drugs.

IMPORTANT NOTE

Payment for covered services is subject to the allowable charge (see "Definitions").

In order for available benefits to apply, all services, with the exception of Preventive Care, must meet all of the following criteria:

- They must be medically necessary and must be furnished in a medically necessary setting.
- They must be furnished in connection with the diagnosis or treatment of a covered illness or injury.
- They must be prescribed and furnished by a physician or other covered provider within the scope of his or her license or certification.
- They must not be excluded from coverage under this plan.
- They must meet the standards in our medical and payment policies. The plan uses policies to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at www.premera.com/wea or by calling WEA Select Customer Service. Please see "Clinical Review" for additional information.
- Expenses must be incurred while the enrollee is covered under this plan.

Throughout the booklet, we use many terms that have specific meaning under this plan. Please see the "Definitions" section of the booklet for details. The terms "you" and "your" refer to the enrollees under this plan. The terms "we," "us," and "our" refer to Premera Blue Cross.

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

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

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

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

Network Providers

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

Network providers are:

- Providers in the Foundation network in Washington. For care in Clark County, Washington, you also have access to providers through the BlueCard® Program. See "BlueCard Program And Other Inter-Plan Arrangements" on page 14 for more details.
- Providers in Alaska that have signed contracts with Premera Blue Cross Blue Shield of Alaska.
- 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 "BlueCard Program And Other Inter-Plan Arrangements" on page 14 for more details.
  - Wyoming: The Host Blue's Traditional (Participating) network
  - All Other States: The Host Blue's PPO (Preferred) network

Participating pharmacies are also network providers and are available nationwide.

Network providers accept reimbursement for services at negotiated fees. These fees are the allowable charges for network providers. When you receive covered services from a network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). Network providers will not charge you more than the allowable charge for covered services. This means that your portion of the charges for covered services will be lower.

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

A list of Foundation network providers can be accessed at any time on www.premera.com/wea. You may also ask for a copy of the directory by calling WEA Select Customer Service at 1-800-932-9221. 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 inside front cover of this booklet and on your Premera Blue Cross ID card.

Non-Network Providers

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

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

- There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers 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 Submit A Claim?" for details.

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

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

In-Network Benefits For Non-Network Providers

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

- Emergency care for a medical emergency is always covered at the in-network level of benefits. (Please see the "Definitions" section for definitions of these terms.) This plan provides worldwide coverage for emergency care.

  The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is a network provider. Emergency care furnished by a non-network provider will be reimbursed on the same basis as a network provider. As explained above, if you see a non-network provider, you may be responsible for amounts that exceed the allowable charge.
- Services from certain categories of providers to which provider contracts are not offered are always covered at the in-network level of benefits. These types of providers are not listed in the provider directory.
- Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers are always covered at the in-network level of benefits.
- You might have a provider who is in Premera Blue Cross's Foundation network, but who does not have admitting privileges at a Foundation hospital. If that provider admits you to a hospital in Washington that is in any of Premera Blue Cross's other provider networks, facility and hospital-based provider services will be covered at the in-network level of benefits.
- Covered services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

If a covered service is not available from a network provider, you can receive benefits for services provided by a non-network provider at the in-network benefit level. However, you must request this before you get the care. See "Prior Authorization" to find out how to do this.

HOW DO I SUBMIT A CLAIM?

Most providers submit their bills to us directly. Once your provider has submitted the bill to us, we will send you an Explanation of Benefits form that shows the amount charged and the amount we paid to the provider. Electronic copies of your Explanation of Benefits are also available by logging into your account at www.premera.com/wea.

1. Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. Use the Subscriber Claim Form, available at www.premera.com/wea or by calling WEA Select Customer Service at 1-800-932-9221.
2. Attach an itemized bill from the provider. Bills will not be considered to be claims until all the necessary information is included.
3. Sign the form in the space provided.
4. Mail your claim to: Premera Blue Cross
   P.O. Box 91059
   Seattle, WA 98111-9159

TIMELY FILING OF CLAIMS

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 on which expenses were incurred for any other services or supplies; or
- For enrollees who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits.

We will not provide benefits for claims we receive after the later of these two dates, nor will we provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline.

HOSPITAL SERVICES

For hospital services, present the Premera Blue Cross identification card to the admitting clerk when admitted to or receiving outpatient services at a Foundation hospital. If admitted to or receiving outpatient services at a hospital not contracted with Premera Blue Cross (Non-Foundation hospital) and the hospital does not bill, submit the itemized bill to us along with a Subscriber Claim Form. You will receive payment directly in order to pay your hospital bills.

PHYSICIAN AND OTHER PROVIDER SERVICES

Foundation Providers

Present the Premera Blue Cross identification card to the provider. The provider will bill us directly. When we send payment for covered services to that provider, we will send you an Explanation of Benefits.

Foundation providers will seek payment for covered services solely from Premera Blue Cross and accept our payment as payment in full. Foundation providers may seek payment from you only for the following:

- Services and/or charges not covered by this plan
- Deductible and coinsurance
- Amounts in excess of stated benefit maximums

Non-Foundation Providers

If you receive services from a provider that has not contracted with Premera Blue Cross and the Subscriber Claim Form indicates that full payment has been made, payment for covered services will be made directly to the enrollee. When there is no indication that the bill has been fully paid, payment will typically be made to the provider or jointly to you and the provider as copayees.

Non-Foundation providers may seek payment from you for the following:

- Amounts above the allowable charge (the difference between what we allow for the service and the provider's actual charge)
- Services and/or charges not covered by this plan
- Deductible and coinsurance
- Amounts in excess of stated benefit maximums

Include the group and subscriber identification numbers on all bills or correspondence. The numbers are listed on your Premera Blue Cross identification card.

For information on how to submit claims from out-of-area providers, please see "The BlueCard® Program (out-of-area services)."

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

THE BLUECARD® PROGRAM (OUT-OF-AREA SERVICES) AND OTHER INTER-PLAN ARRANGEMENTS

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

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

Network Providers

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

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

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

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

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

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

Clark County Providers

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

Non-Network Providers

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

Exceptions Required By Law

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

BlueCard ®Worldwide

If you're outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide when accessing covered health services. BlueCard Worldwide is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although BlueCard Worldwide provides a network of contracting inpatient hospitals, it offers only referrals to doctors and other outpatient providers. Also, when you receive care from doctors and other outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you'll typically have to submit the claims yourself to obtain reimbursement for these services.

Value-Based Programs

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

Further Questions?

If you have questions or need more information about the Inter-Plan Arrangements, including the BlueCard Program, please call WEA Select Customer Service. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, go to our Web site or call the toll-free BlueCard number; both are shown on the inside front cover of your booklet. You can also get BlueCard Worldwide information by calling the toll-free phone number.

Services Received In Counties Bordering Washington

When you receive care from providers located in states bordering Washington (Oregon and Idaho), claims for covered services will be processed through the BlueCard Program as described elsewhere. There are providers located in Oregon and Idaho contiguous counties who contract directly with us. Claims for covered services from these providers will be processed directly by Premera Blue Cross. You can find contracting providers by contacting WEA Select Customer Service, or checking our on-line provider directory at www.premera.com/wea.

WHAT IS THE ROLE OF INTEGRATED HEALTH MANAGEMENT AND CASE MANAGEMENT?

INTEGRATED HEALTH MANAGEMENT

Integrated Health Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Integrated Health Management process is simple but important.

In order for your plan to pay claims, you must be eligible on the dates of service and services must be medically necessary. We encourage you to call WEA Select Customer Service to verify that you meet the required criteria for claims payment and to help us identify admissions which might benefit from case management.

PRIOR AUTHORIZATION

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

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

There are three situations where prior authorization is required:

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

How To Ask For Prior Authorization

The plan has a specific list of services that must have prior authorization with any provider. The list can be found at www.premera.com/wea. Before you receive services, we suggest that you review this list. The services, devices and drugs on the prior authorization list need to be reviewed to make sure that they are medically necessary for you and meet this plan's other standards for coverage. It is to your advantage to know in advance if the plan would not cover them.

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

Services From Non-Network Providers: It is your responsibility to get prior authorization for any services that are on the prior authorization list when you see a non-network provider. You can call us at the number listed on your ID card to request a prior authorization. The non-network provider may agree to make the request for you. However, you should call us to make sure we have approved the prior authorization request in writing before you receive the services.

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

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

Exceptions

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

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

Prior Authorization For Prescription Drugs

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

You can buy the prescription drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowable charge. See "How Do I Submit A Claim?" for details.

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

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

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

Services from Non-Network Providers

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

The prior authorization request must include the following:

- A statement that the non-network provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from a network provider.
- Any necessary medical records supporting the request.
- If the request is approved, the services will be covered at the in-network cost-share. In addition to the cost-shares, you will be required to pay any amounts over the allowable charge if the provider does not

have an agreement with us or, for out-of-state providers, with the local Blue Cross and/or Blue Shield Licensee.

CLINICAL REVIEW

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

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

Please see “Important Note” in the Introduction section, for additional information.

CASE MANAGEMENT

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

To request additional Case Management information or to make a Case Management referral call toll-free 1-800-344-2227.

APPEALS REVIEW

Should you or your provider disagree with an Integrated Health Management determination, please refer to the procedures outlined under "Complaints And Appeals."

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

CALENDAR YEAR DEDUCTIBLE

The calendar year deductible is the amount you must pay each year before your plan benefits are available to you. It applies to **all** benefits, except as specified.

When a subscriber covers family members, benefits will begin for all family members once the family deductible is met.

Your calendar year deductibles are as follows:

- **Foundation Providers** .... $1,500 per subscriber and $3,000 per family*, per calendar year
- **Non-Foundation Providers** .... $3,000 per subscriber and $6,000 per family*, per calendar year
- **Prescription Drugs** .... Subject to your in-network medical deductible.

(* Family = 2 or more enrollees)

Please note:

- The calendar year deductible is in addition to any required coinsurance.
- Amounts credited to the calendar year deductible are not credited toward any dollar maximums that a particular benefit may have. (Please note that some benefits have other types of maximums, such as visits or days of care.)
- A new deductible is required at the start of each calendar year.
- The amount credited toward the calendar year deductible for any covered service or supply won’t

exceed the allowable charge.

COINSURANCE

Coinsurance is a percentage of the allowable charge that you must pay for certain services and supplies. Coinsurance does not apply toward the calendar year deductible.

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges; there is no out-of-pocket maximum for Non-Foundation provider charges

OUT-OF-POCKET MAXIMUM

Out-of-pocket maximum amounts are also aggregate, requiring the family out-of-pocket maximum to be met before all services are covered at 100% of allowable charges for any single family member.

- **Foundation Providers: Foundation Providers:** Your out-of-pocket maximum for covered services, which includes your deductible and in-network coinsurance, is $4,000 per subscriber or $8,000 per family*, per calendar year. Once the subscriber has paid $4,000, or $8,000 per family*, in out-of-pocket expenses for services from Foundation providers, medical and prescription benefits will be provided at 100% of allowable charges for the remainder of the calendar year.
- **Non-Foundation Providers:** There is no out-of-pocket maximum for out-of-network providers.

(* Family = 2 or more enrollees)

The out-of-pocket maximum for Foundation providers **does not include** any of the following:

- Amounts you pay to Non-Foundation providers. However, benefits that always apply in-network cost-shares, like Emergency Room Services, will apply toward the out-of-pocket maximum.
- Amounts you pay for non-covered services, or services for which benefits have been exhausted.
- Amounts over the allowable charge.

WHAT ARE MY BENEFITS?

Acupuncture Services

Benefits are provided for medically necessary acupuncture services to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition. Covered services will be paid **up to 12 visits per calendar year** as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Ambulance Services

Benefits are provided for licensed ambulance service to the nearest facility equipped to treat the condition only when other means would endanger your health and safety. This benefit is not available for private automobiles or taxi services, nor for the convenience of the patient or family.

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges

Blood and Blood Products

Benefits are provided for blood products and their administration.

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable

charges; plan pays 80% of allowable charges

- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Chemical Dependency/Behavioral Health Treatment (Inpatient and Outpatient)

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services as follows:

Facility Care

Benefits include inpatient and outpatient services furnished and billed by a facility, including professional services and visits received while an inpatient.

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Outpatient Professional Visits

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Covered services include medically necessary inpatient and outpatient services, including methadone treatment, when received from a state-approved facility or program for the treatment of chemical dependency.

Chemical dependency is an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. For the purpose of chemical dependency treatment, benefits for "medically necessary" services will be determined in accordance with the current edition of the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders, as published by the American Society of Addiction Medicine.

An approved treatment facility is a facility approved in the State of Washington pursuant to RCW 70.96A.020(2) or RCW 69.54.030, in the State of Alaska pursuant to Chapter 47.37 AS, or an approved facility in any other state in accordance with the licensing or certification requirements in the jurisdiction where services are rendered which provides an organized program of treatment for chemical dependency.

Chemical dependency benefits *will not* be provided for:

- Treatment of alcohol or drug use or abuse that does not meet the definition of “Chemical Dependency” as stated above.
- Voluntary support groups such as Alanon, Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous
- Separate charges for transportation, records and reports
- Court-ordered services; services related to deferred prosecution, deferred sentencing or suspended sentencing; or services related to motor vehicle driving rights unless deemed medically necessary by Premera Blue Cross
- Halfway houses, quarterway houses, recovery houses, and other sober living residences
- Outward bound, wilderness, camping or tall ship programs or activities
- Residential treatment programs or facilities that are not units of legally operated hospitals, or that are

not state licensed or approved facilities for the provision of residential chemical dependency treatment

Please see "What's Not Covered?" for other limitations and exclusions

Treatment for detoxification services will be paid as any other medical condition. See "Definitions."

Clinical Trials

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

Benefits are based on the type of service you get. For example, benefits for an office visit are covered under the Office Visits (Office and Home) benefit and lab tests are covered under the Diagnostic Imaging and Laboratory Services benefit.

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

A "clinical trial" does not include expenses for:

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

Please contact WEA Select Customer Service before you enroll in a clinical trial. We can help you verify that the clinical trial is a qualified clinical trial. You may also be assigned a nurse case manager to work with you and your provider. See "What Is The Role Of Integrated Health Management And Case Management?" for details.

Contraceptive Services

Benefits for female enrollees are provided as follows:

- **Foundation Providers:** The plan pays 100% of allowable charges; no calendar year deductible
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Benefits for male enrollees are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Benefits are provided for the following contraceptive services, drugs and supplies:

- Office visits and consultations related to contraception
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)

- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility charges will be subject to your cost-shares under the applicable benefit and are not covered by this benefit. See Surgical And Medical Care (Professional) on page 41 and Hospital Services (Inpatient and Outpatient) on page 25.
- Prescription drugs and devices. See "Prescription Drugs" on page 32. Your prescription drug cost-share is waived for devices and for generic and single-source brand name birth control drugs, when you get them from a participating pharmacy. Examples of covered devices are diaphragms and cervical caps.

Benefits are not provided for non-prescription male contraceptive drugs, supplies or devices; reversal of sterilization; or services, drugs or supplies for fertility enhancement.

Hysterectomy services are covered on the same basis as other surgeries. See Surgical And Medical Care (Professional) on page 41 and Hospital Services (Inpatient and Outpatient) on page 25.

Dental Services

Benefits are provided for dental services for treatment of a fractured jaw or injury affecting functionally sound natural teeth if treatment is received within 12 months of the injury or when the result of a medical condition or complication of a covered medical condition, as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Benefits are provided for the repreparation or repair of the natural tooth structure and dental implants and include the services of a licensed dentist (D.M.D. or D.D.S.) or denturist. This benefit will not be provided for injuries caused by biting or chewing. "Functionally sound natural teeth" means the affected teeth are living, natural teeth free from decay and do not, at the time of the injury, have extensive restoration, veneer, crowns or splints; periodontal disease or another condition that would have caused the teeth to be in a weakened state before the injury.

This plan also will cover hospital or ambulatory surgical center care for dental procedures, and general anesthesia and related facility services that are medically necessary. This benefit is limited to one of the following two reasons:

1. The enrollee is under age 7 or is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office;
2. The enrollee has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a hospital or ambulatory surgical center.

Diagnostic Imaging and Laboratory Services

Diagnostic imaging and scans (including X-rays and EKGs), laboratory services, and pathology tests recommended by your physician, advanced registered nurse practitioner or physician's assistant are covered as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

For more information on how sleep studies are covered, please call WEA Select Customer Service at 1-800-932-9221.

Some imaging and laboratory services are covered as part of preventive care. Please see "Preventive Care" on page 36 and "Preventive Screenings" on 37.

Dialysis

When you have end-stage renal disease (ESRD) you may be eligible to enroll in Medicare. If eligible, it is

important to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

Benefits are subject to the same calendar year deductible and coinsurance as you would pay for outpatient sevices for other covered medical conditions.

If the dialysis services are provided by a non-network provider then you will owe the difference between the non-network provider's billed charges and the payment we will make for the covered services. See the “Allowable Charge” definition for more information.

Emergency Room Services

Benefits are provided for services received from a hospital emergency room. You pay:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges

Please note: You may receive a separate bill for emergency room physician services. Out-of-network physicians may also bill for amounts over the Premera allowable charge.

Please also see Office Visits regarding non-hospital Urgent Care Centers, which may be an appropriate alternative in some situations.

Health Management

Benefits are only provided when services are furnished by a Foundation provider. For help in finding covered providers, please call WEA Select Customer Service. You pay:

- **Foundation Providers:** The plan pays 100% of allowable charges; no calendar year deductible
- **Non-Foundation Providers:** Benefits are not covered

Health Education

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

Nicotine Dependency Programs

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

For nicotine dependency prescription drugs and supplies benefit information, see "Prescription Drugs" on page 32.

Office visits for nicotine dependency are covered as any other office visit. For more information please see "Office Visits (Office and Home)" on page 31.

Home Health Care

Benefits are provided to homebound enrollees for the treatment of a covered medical condition or injury requiring medically necessary skilled care. Benefits are **limited to 130 visits** each calendar year. Home health care visits provided as an alternative to inpatient hospitalization are not subject to this limit. Benefits are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

To be covered, home health care cannot be maintenance or custodial care. It must meet *all* of

these requirements:

- Provide skilled medical care, as described in this section*
- Be furnished and billed by a covered home health agency, as described in “Home Health Care”
- Be "medically necessary" and not maintenance or custodial care (see "Definitions")*
- Be included in a home health care plan of treatment*

* **Note:** Benefits may not be provided for every service or supply included in the treatment plan. We may exclude or limit benefits for home health care services unless such services are both skilled medical care and medically necessary. A covered home health agency is a provider that is Medicare-certified as a home health agency, or licensed or approved as a home health agency according to the applicable laws of the state in which it operates.

Skilled medical care means services primarily to treat an illness or injury which can only be furnished by a health care provider with specific medical knowledge and technical training, such as a registered nurse, a physical therapist, a speech therapist or a respiratory therapist.

Examples of skilled medical care include:

- Intramuscular or intravenous administration of medication
- Complex dressing changes
- Monitoring unstable vital signs
- Acute respiratory care
- Physical, occupational, and speech therapy

Covered services are:

- Intermittent Skilled Home Care Visits. A visit requiring a reasonable amount of time to do a specific skilled medical service which must be performed by an employee of the home health agency who is a registered nurse; a licensed practical nurse; a licensed or registered physical therapist or occupational therapist; a certified respiratory therapist; or a speech therapist certified by the American Speech, Language, and Hearing Association. Benefits are also provided for appropriate services of a Medical Social Worker performing services specified in the treatment plan.
- Intermittent Home Health Aide Services. Only covered when performed concurrently with skilled care and under the direct supervision of one of the providers listed under "Intermittent Skilled Home Care Visits," above. Only intermittent, not continuous, visits are covered.
- Durable medical equipment, medical supplies and prescription drugs prescribed by a physician as part of home health care. (Such medical equipment and supplies are not subject to the benefit maximums stated in “Prosthetics, Orthotics and Medical Equipment” on page 37).

Skilled care does not include services that are primarily for ongoing maintenance of the enrollee’s health, rather than treatment of an illness or injury, even if furnished by one of the above-named health care providers. In addition to exclusions and limitations stated under "What's Not Covered?" benefits are not provided for:

- Home care provided on an "around-the-clock," 24-hour, or continuous basis
- Custodial or maintenance care (see "Definitions")
- Homemaker or housekeeping services
- Supportive environmental materials, such as handrails or ramps
- Social services
- Psychiatric conditions
- Separate transportation charges

For information on home health care and an explanation of medically necessary skilled care versus maintenance/custodial care, please call WEA Select Customer Service at:

Toll-Free: 1-800-932-9221

Hearing-impaired TDD: 1-800-842-5357

Hospice Care

Benefits will be available only during the enrollee's last six months of life, as determined by the patient's physician and beginning on the first day of covered hospice care, as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

To be covered, hospice care services must be furnished and billed by a Medicare-certified hospice agency or state-licensed or state-certified hospice agency in the state in which it operates. Services must be part of a written plan of care prescribed and periodically reviewed by a physician (M.D. or D.O.) and subject to Premera Blue Cross's utilization review. The plan of care must describe the services and supplies for the palliative care and medically necessary treatment to be provided to the enrollee. The physician must certify that the enrollee is terminally ill and that hospital or skilled nursing home confinement would be required in the absence of hospice care.

The six-month period begins on the initial date of hospice care covered under this plan.

Home care up to a maximum of six months is provided for:

- Visits by each of the following for intermittent care: a registered or licensed practical nurse; a licensed physical therapist; a certified respiratory therapist; an American Speech and Hearing Association certified speech therapist; a certified occupational therapist; a master of social work; or a home health aide who is directly supervised by one of the above providers (performing services prescribed in the plan of care)
- Prescription drugs and insulin directly related to treatment of the terminal illness
- Medical supplies normally used for hospital inpatients, such as oxygen, catheters, needles, syringes, dressings, materials used in aseptic techniques, irrigation solutions and intravenous solutions
- Rental of durable medical apparatus and medical equipment such as wheelchairs, hospital beds, respirators, splints, trusses, braces or crutches needed for treatment
- **Up to 240 hours of respite care** for a homebound enrollee

You are also covered **up to 10 days of inpatient care** in a hospice that is Medicare-certified or state-licensed or state-certified by the state in which it operates when ordered by the attending physician (M.D. or D.O.).

In addition to the limitations and exclusions found elsewhere in this benefit booklet, benefits are not available for the following: services provided to someone other than the terminally ill enrollee, including bereavement counseling; pastoral and spiritual counseling; services performed by family members or volunteer workers; homemaker or housekeeping services, except by home health aides as ordered in the hospice plan of care; supportive environmental materials such as handrails, ramps, air conditioners and telephones; expenses for the normal necessities of living, such as food, clothing and household supplies; dietary assistance (for example, "Meals on Wheels") or nutritional guidance; separate charges for reports, records or transportation; legal and financial counseling services; services and supplies not included in the hospice plan of care or not specifically set forth as a covered expense; services and supplies in excess of the specified limitations; services furnished by a hospice that is not Medicare-certified as such or state-licensed or state-certified as such by the state in which it operates.

Hospital Services (Inpatient and Outpatient)

Benefits are provided for the services of a legally operated hospital, including inpatient and outpatient care, as follows:

Inpatient Care: Benefits are provided for room and board, related ancillary services, and use of an intensive, coronary or constant care unit as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable

charges; plan pays 80% of allowable charges

- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Charges for radio, television, long-distance telephone calls, meals for guests and personal comfort items are not covered.

Outpatient Services: Benefits are provided for covered services, as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Infusion Therapy

For outpatient professional services, supplies, drugs and solutions required for infusion therapy, benefits will be paid as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Infusion therapy (also known as intravenous therapy) is the administration of fluids into a vein by means of a needle or catheter, most often for the following purposes:

- Maintain fluid and electrolyte balance
- Correct fluid volume deficiencies after excessive loss of body fluids
- Help enrollees who are unable to take sufficient volumes of fluids orally
- Provide prolonged nutritional support for enrollees with gastrointestinal dysfunction

This benefit doesn’t cover:

- Charges in excess of the average wholesale price for drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements

Mastectomy And Breast Reconstruction

Inpatient and outpatient benefits are provided for a mastectomy necessary due to illness or injury, as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Consistent with the requirements of the Women's Health and Cancer Rights Act of 1998, this plan provides benefits for mastectomy-related services. For any enrollee electing breast reconstruction in connection with a mastectomy, this benefit covers:

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

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

Medical Foods

Benefits for medical foods used to supplement or replace an enrollee's diet, or for the treatment of inborn errors of metabolism (e.g. phenylketonuria or PKU), are provided when medically necessary as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges.

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

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

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

Mental Health Care/Behavioral Health (Inpatient and Outpatient)

This benefit provides inpatient and outpatient treatment of mental health conditions, including treatment of eating disorders such as anorexia nervosa, bulimia or any similar condition. Services must be consistent with generally recognized standards within a relevant health profession. Also covered under this benefit are outpatient biofeedback services for generalized anxiety disorder when provided by a qualified provider. Benefits also include physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders.

Inpatient Mental Health Care

When confined as a bed patient in a legally operated hospital or a state hospital operated and maintained by the State of Washington for the care of the mentally ill, benefits for physician and hospital services to treat the covered mental condition are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

However, outpatient mental health care services from licensed or certified providers received while in residential treatment may be covered if we determine they are medically necessary.

Please call WEA Select Customer Service for specific inpatient mental health care benefit information at:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

Outpatient Mental Health Care

When not confined as a bed patient in a hospital, medically necessary services for mental health conditions are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Services must be provided by a legally operated hospital, or a state hospital which is operated and maintained by the State of Washington for the care of the mentally ill, a licensed physician, a licensed psychologist or a community mental health agency*. Benefits will also be provided for services rendered by an Advanced Registered Nurse Practitioner (ARNP), a Licensed Clinical Social Worker (LCSW), a State-Certified Clinical Social Worker (CCSW), a State-Certified Mental Health Counselor (CMHC),

Agency Affiliated Counselors (AAC), Certified Advisor (CA), Certified Counselor (CC), Licensed Social Work Associate-Advanced (LSWA-A), Licensed Social Work Associate-Independent Clinical (LSWA-IC), Licensed Mental Health Counselor Associate (LMHCA), Licensed Marriage and Family Therapist Associate (LMFTA), Certified Chemical Dependency Professional Trainee (CDPT), any other state-certified master's-level mental health provider, or any other provider (see "Definitions") performing services within his or her permitted scope of practice.

*A community mental health agency is a health care provider which is licensed as a community mental health agency by the Washington State Department of Social and Health Services and which has a plan in effect for quality assurance, peer review and supervision by a physician or licensed psychologist.

Mental health benefits *will not* be provided for:

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

Applied Behavioral Analysis (ABA) Therapy

This plan covers Applied Behavioral Analysis (ABA) Therapy. The member must be diagnosed with one of the following disorders:

- Autistic disorder
- Autism spectrum disorder
- Asperger's disorder
- Childhood disintegrative disorder
- Pervasive developmental disorder
- Rett’s disorder

Covered Providers Benefits must be provided by**:**

- A physician (MD or DO) who is a psychiatrist, developmental pediatrician, or pediatric neurologist
- A state-licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A state-licensed masters-level mental health clinician (e.g., licensed clinical social worker, licensed marriage and family counselor, licensed mental health counselor)
- A state licensed occupational or speech therapist when providing ABA services
- A state licensed psychologist
- Licensed Community Mental Health or Behavioral Health agency that is also state certified for ABA
- Board certified Behavior Analyst, licensed in states with behavior analyst licensure, otherwise, certified by the Behavior Analyst Certification Board
- Therapy assistants/behavioral technicians/paraprofessionals; when services are supervised and billed by a licensed provider or Board Certified Behavioral Analyst (BCBA)

Covered Services Include:

- Direct treatment or direct therapy services for identified patients and/or family members when provided by a licensed provider, BCBA, or therapy assistants who are supervised by a licensed provider or BCBA.
- Also covered when performed by a licensed provider or BCBA:
  - Initial evaluation/assessment
  - Treatment review and planning
  - Supervision of therapy assistants

- Communication/coordination with other providers or school personnel

Please note: Delivery of all ABA services for an individual may be managed by a BCBA or licensed provider who is called a Program Manager.

This benefit does not cover:

- Training of therapy assistants/behavioral technicians/paraprofessionals (as distinct from supervision)
- Accompanying the member/identified patient to appointments or activities outside of the home (e.g. recreational activities, eating out, shopping, play activities, medical appointments), except when the member/identified patient has demonstrated a pattern of significant behavioral difficulties during specific activities
- Transporting the member/identified patient in lieu of parental/other family member transport
- Assisting the member with academic work or functioning as a tutor, except when the member has demonstrated a pattern of significant behavioral difficulties during school work
- Functioning as an educational or other aide for the member/identified patient in school
- Provision of services that are part of an Individualized Education Program (IEP) and therefore should be provided by school personnel, or other services that schools are obligated to provide
- Provider doing house work or chores, or assisting the member/identified patient with house work or chores, except when the member has demonstrated a pattern of significant behavioral difficulties during specific house work or chores, or acquiring the skills to do specific house work or chores is part of the ABA treatment plan for the member/identified patient
- Provider travel time
- Babysitting
- Respite for parents/family members
- Provider residing in the member's home and functioning as live-in help (e.g. in an au-pair role)
- Peer-mediated groups or interventions
- Training or classes for groups of parents of different patients
- Hippotherapy/equestrian therapy
- Pet therapy
- Auditory Integration Therapy
- Sensory Integration Therapy
- Prescription drugs. These are covered under the Prescription Drugs benefit
- Any other activity that is not considered to be a behavioral assessment or intervention utilizing applied behavior analysis techniques

Neurodevelopmental Therapy (Inpatient and Outpatient)

Benefits are provided for inpatient and outpatient neurodevelopmental therapy. Benefits may include speech and hearing therapy, physical therapy, massage therapy, rehabilitative counseling and functional occupational therapy when the following criteria are met:

- The care restores or improves lost body functions, or maintains function, related to neurodevelopmental delay or deficiencies (neurological and body functions that fail to develop normally after birth) where significant deterioration would occur without the services
- Treatment is appropriate to the condition being treated
- The treatment is part of a formal written program of treatment prescribed by a physician
- Services must be furnished and billed by a legally operated hospital, by a physician (M.D. or D.O.), or by a massage practitioner, physical, occupational or speech therapist

Physical, speech and occupational therapy for treatment of a mental health condition are provided as part of the mental health benefit and are not subject to an age limit. See the "Mental Health/Behavioral Health (Inpatient and Outpatient)" benefit for additional information.

Inpatient Neurodevelopmental Therapy

Benefits are provided **up to 30 days each calendar year** in a legally operated hospital, as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Outpatient Neurodevelopmental Therapy

Benefits are provided **up to 15 visits per calendar year** for all forms of therapy combined. A "visit" is a session of treatment for each type of therapy. Each type of therapy accrues toward the visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different providers. Benefits are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Benefits are not provided for:

- Convalescent care when the need for definitive medical treatment no longer exists or when an inpatient level of care is no longer medically necessary
- Social, cultural, and vocational therapy
- Acupressure
- Services provided by employees of a home health agency or hospice

Please see "What's Not Covered?" for additional limitations and exclusions.

Newborn Care

Newborn children are covered automatically for the first three weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. The enrollment guidelines outlined in "Who Is Eligible For Coverage And When?" will need to be followed in the following situations:

- The mother is not eligible for obstetrical care benefits under this plan and the subscriber wishes to add coverage for the newborn, or
- The subscriber wishes to add coverage for the newborn child beyond the three-week period

When the child meets the coverage requirements outlined above, the regular benefits of this plan will apply, subject to the child's own deductible and coinsurance requirements.

Services must be ordered by the attending provider (a physician, a physician's assistant, a certified nurse midwife, a licensed midwife or an advanced registered nurse practitioner) in consultation with the mother. Some examples include:

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

  Please Note: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.
- **Professional Care:** Inpatient newborn care and follow-up care consistent with accepted medical practice when ordered by the attending provider in consultation with the mother. Follow-up care

includes services of the attending provider, a home health agency and/or a registered nurse. Circumcision is also covered.

For immunizations and outpatient well-baby care, please see “Preventive Care" on page 36.

Nutritional Therapy

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury, including services to manage diabetes as follows:

- **Foundation Providers:** The plan pays 100% of allowable charges; no calendar year deductible
- **Non-Foundation Providers:** Benefits are not covered.

For additional preventive care benefit information, see “Preventive Care” on page 36.

Obstetrical (Maternity) Care

Pregnancy, childbirth and voluntary termination of pregnancy are covered as any other condition for all covered enrollees. If the attending provider (physician, a physician’s assistant, a certified nurse midwife, a licensed midwife or an advanced registered nurse practitioner) bills a single fee for childbirth that includes prenatal and postpartum services, this plan will cover that fee as it would any other surgery. Obstetrical care benefits include:

- **Hospital Care:** Inpatient, outpatient and emergency room services, including inpatient post-delivery hospital care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

  Please Note: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.
- **Professional Care:**
  - Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
  - Delivery, including cesarean section
  - Postpartum care consistent with accepted medical practice when ordered by the attending provider in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

Office Visits (Office and Home)

The plan pays for one visit per physician or provider (see "Definitions") per day in the physician’s office or enrollee’s home. This benefit also includes services of a naturopathic physician to treat a covered condition, surgical opinion consultations and non-hospital urgent care center visits.

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

A "visit" is a personal interview between the enrollee and the physician or provider.

Your plan covers access to in-network care via online and telephonic methods. Your in-network provider will determine which conditions and circumstances are appropriate for telehealth services. Services delivered via telehealth methods are subject to standard office visit cost-shares and other provisions as stated in this booklet.

The following are not covered under this benefit:

- Any related charges, such as diagnostic X-ray and laboratory services, which may be covered under

"Diagnostic Imaging and Laboratory Services" on page 22.

- Visits made at the time of a surgical procedure, or during that surgery's pre- or post-operative care periods.
- Preventive care, psychiatric conditions, or chemical dependency. These services may be covered under other benefits.

For spinal manipulations, please see "Spinal Manipulations and Associated Services" on page 41.

For diagnosis and treatment of temporomandibular joint (TMJ) disorders benefit information, please see the Temporomandibular Joint (TMJ) Disorders benefit on page 42.

Please see "What's Not Covered?" for additional limitations and exclusions.

Prescription Drugs

The following topics are detailed below:

- Dispensing Limit
- Specialty Pharmacy Prescriptions
- What's Covered
- Exclusions
- Prescription Drug Volume Discount
- Your Right to Safe and Effective Pharmacy Services
- Questions and Answers About Your Prescription Drug Benefits

This benefit covers medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for use outside of a medical facility and dispensed by a licensed pharmacist in a state-licensed pharmacy where it is located. Also included are injectable supplies (please see "Injectable Supplies" below for more information). A prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription."

Benefits are subject to your in-network calendar year deductible and coinsurance.

However, benefits for preventive care prescription drugs will not be subject to your calendar year deductible and coinsurance. Preventive care prescription drugs are drugs that can be taken for heart disease prevention or to prevent the reoccurrence of heart disease. These preventive care drugs include only generic cardiovascular drugs, as determined by us, utilizing the American Hospital Formulary Service (AHFS) as a reference. For example, treatment of high cholesterol with cholesterol-lowering medications or medication that can be taken to prevent heart disease or medications that can be used to treat a recovered heart attack or stroke victim constitute preventive care prescription drugs.

For more about your prescription drugs' tiers and other pharmacy information, please go to www.premera.com/wea, click on Enrollee Services, then Pharmacy.

Please note: In no case will the enrollee's out-of-pocket expense exceed the cost of the drug or supply.

Dispensing Limit

Retail Pharmacy Prescriptions: Up to a 30-day supply is covered unless the drug maker's packaging limits the supply in some other way.

Mail-Order Pharmacy Prescriptions: This benefit is limited to our participating home delivery pharmacy. Up to a 90-day supply is covered unless the drug maker's packaging limits the supply in some other way. Dispensing of an amount more than a 90-day supply is permitted when the drug maker's packaging doesn't allow for a specific 90-day amount.

You can lower your out-of-pocket costs by using a pharmacy. These pharmacies agree not to charge you more than the allowable charge for covered drugs, and will submit claims directly to us. By showing your Premera Blue Cross ID card at a pharmacy, you will not be charged more than the allowable charge for covered drugs. If you use a non-participating pharmacy (or don't show your Premera Blue Cross ID card at a participating pharmacy), you will be required to pay the full retail price for the drug, and submit a claim. Your reimbursement, however, will be based on the allowable charge for the covered drugs.

For a list of pharmacies, please call WEA Select Customer Service at 1-800-932-9221 or the toll-free Pharmacy Locator Line on the back of your Premera Blue Cross ID card. You may also find pharmacies at www.premera.com/wea and click on "Find a Doctor" at the top of the page.

Specialty Pharmacy Prescriptions: This plan will only cover specialty drugs that are dispensed by a network specialty pharmacy. This benefit is limited to a 30-day supply. Contact WEA Select Customer Service for details on which drugs are included in the specialty pharmacy program, or visit our website, which is shown on the back cover of this booklet.

"Specialty drugs" are medications that require special handling, storage or transport, or patient monitoring to determine medical effectiveness. They are used to treat complex or rare conditions, including multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Specialty drugs can be dispensed by one of our network specialty pharmacies. For more information about this plan, the pharmacies and a list of specialty drugs, please visit www.premera.com/wea, click on Enrollee Services, then Pharmacy. Or you can call WEA Select Customer Service at 1-800-932-9221.

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

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

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of "Prescription Drug" (See "Definitions").
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Medically necessary, self-administered oral chemotherapy medication that can be used to kill cancerous cells or slow their growth when the medication is dispensed by a pharmacy.
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also included are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Prescription nicotine dependency drugs
- Prescription drugs and generic over-the-counter drugs for the treatment of nicotine dependency
- Over-the-counter female contraceptives that are prescribed by your healthcare provider and purchased through a licensed pharmacy are covered. No cost-share is required when you get them through a participating pharmacy. **Please have your prescription ready for the pharmacist.**
- Prescription contraceptive drugs (including generic emergency birth control) and devices (e.g., oral drugs, diaphragms and cervical caps)

Exclusions This benefit doesn't cover:

- Drugs and medicines that may be lawfully obtained without a prescription (over the counter, or OTC), except as required by state or federal law or regulation. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples include, but aren't limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g., infant formulas or protein supplements)
- Non-prescription contraceptive methods (e.g., jellies, creams, foams or devices) except as stated in the "What's Covered" section.
- Drugs for cosmetic use, or which promote or stimulate hair growth
- Drugs for experimental or investigational use

- Biologicals, blood or blood derivatives, which are covered under other benefits when medically necessary and appropriate
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility. Services are covered under other benefits when medically necessary and appropriate
- Replacement of lost, stolen, or damaged medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications; (the exception is injectable drugs for self-administration, such as insulin, growth hormone and glucagon); please see "Infusion Therapy" on page 26.
- Drugs to treat infertility, including fertility enhancement medications
- Weight loss drugs
- Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit) are found under "Prosthetics, Orthotics and Medical Equipment" on page 37.
- Immunization agents and vaccines, including the professional services to administer them; please see "Preventive Care" on page 36.

Prescription Drug Volume Discount Program: Your prescription drug program includes per claim rebates that are received by Premera Blue Cross from its pharmacy benefit manager. These rebates are paid or credited to your group plan and are not reflected in your cost share. The allowable charge that your payment is based upon for prescription drugs is higher than the price we pay our pharmacy benefit manager for those prescription drugs. Premera Blue Cross retains the difference and applies it to the cost of our operations and the prescription drug benefit program. If your prescription drug benefit includes a copay, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowable charge.

Your Right To Safe And Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call WEA Select Customer Service.

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

Questions And Answers About Your Prescription Drug Benefits

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

   Your prescription drug benefit uses a preferred drug list (sometimes referred to as a formulary). We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the preferred list.

   Your plan encourages the use of appropriate "generic drugs" (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand-name drug. A "generic drug" is a prescription drug product manufactured and distributed after the brand-name drug patent of the innovator company has expired. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration (FDA) and are considered by the FDA to be therapeutically equivalent to the brand-name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand-name drug.

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

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

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

   Our Pharmacy and Therapeutics Committee reviews the preferred drug list frequently throughout the year. This committee includes medical practitioners and pharmacists from the community. They review current medical studies and pharmaceutical information to decide which drugs to include on the preferred list.

   If you're taking a drug that's changed from preferred to non-preferred status, we'll notify you before the change. The amount you pay for a drug is based on the drug's designation (as a generic, preferred or non-preferred drug) on the date it's dispensed. The pharmacy's status as participating or non-participating on the date the drug is dispensed is also a factor.

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

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

   You can appeal any decision you disagree with. Please see "Complaints And Appeals" or call WEA Select Customer Service for information on how to initiate an appeal.

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

   The amount you pay for covered drugs is described in "Prescription Drugs" on page 32.

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

   Yes. You may have lower out-of-pocket costs when you have your prescriptions filled by participating pharmacies. The majority of pharmacies in Washington are part of our pharmacy network. Your benefit covers non-speciality prescription drugs dispensed from a non-participating pharmacy at the in-network benefit level; however, benefit coverage is based on the allowable charge and you may be required to pay for any charges above the allowable.

   You can find a participating pharmacy near you by consulting your provider directory (online at www.premera.com/wea and click on "Find a Doctor" at the top of the page), or by calling the Pharmacy Locator Line at the toll-free telephone number found on the back of your ID card.

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

   The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies, home delivery pharmacy, and specialty pharmacy benefits are described in "Prescription Drugs" on page 32.

   In certain circumstances, we may limit benefits for a specific drug, dosage or strength, or limit the quantity appropriate for the usual course of treatment. In making this determination, we take into consideration accepted pharmacy practice standards, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines and standard reference compendia.

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

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

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

   This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by

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

Preventive Care

Benefits are provided for preventive care services as follows:

- **Foundation Providers:** The plan pays 100% of allowable charges; no calendar year deductible
- **Non-Foundation Providers:** Benefits are not covered, unless otherwise stated.

What Are Preventive Services?

Preventive services are defined as follows:

- Evidence-based items or services with a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Also included are additional preventive care and screenings for women not described above in this paragraph as provided for in comprehensive guidelines supported by the U.S. Health Resources and Services Administration.
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the U.S. Health Resources and Services Administration.
- Services that meet the guidelines for preventive care under Washington state law.

A full list of these preventive services is available on www.premera.com/wea or by calling WEA Select Customer Service at 1-800-932-9221. The list also provides the guidelines on how often the services should be provided and who should receive them. Not all services recommended or billed by your doctor as part of your routine physical may comply with these guidelines. The list and guidelines are subject to change as required by law and regulation.

Please note: Some clinics or physician’s offices that are based in or owned by a hospital may charge a separate facility fee for use of an exam or treatment room for all physician visits, including preventive service visits. These fees may not be covered by your preventive benefits and may result in an added out-of-pocket cost to you. When preventive care is only available in clinics that charge a facility fee, we will make an exception to cover the fee under the preventive benefit. If you feel that you have been charged this fee in error you may also file a complaint or ask for an appeal. See "Complaints and Appeals" or contact WEA Select Customer Service.

Preventive services

Benefits are provided for the following preventive services when they meet the federal guidelines above:

- Routine physical exams
- Well-baby and well-child exams
- Physical exams related to school, sports and employment
- Immunizations provided in an office setting
- Seasonal immunizations and certain other immunizations, such as flu shots, flu mist, pneumonia immunizations, whooping cough and adult shingles immunizations, are covered at 100% of allowable charges, in-network and out-of-network, when done by any pharmacy or other mass immunizer location.
- Women’s preventive care including, but not limited to, contraceptive counseling, breast feeding counseling, maternity diagnostic screening, screening for gestational diabetes and counseling about sexually transmitted infections.
- Professional services to prevent falling for enrollees who are age 65 or older and have a history of falling or mobility issues.
- Preventive imaging (including x-ray) and laboratory services
- Screening mammography

- BRCA genetic testing for women at risk for certain breast cancers
- Prostate, cervical and colon cancer screenings
- Preventive colonoscopies, sigmoidoscopies and barium enemas, including facility, anesthesia and professional services. Coverage will be provided for general anesthesia that is delivered by an anesthesiologist for certain procedures only if it meets medical criteria. Removal of polyps during a screening colonoscopy is also covered as part of the preventive screening. For more information contact WEA Select Customer Service.

For all outpatient **non-preventive** diagnostic imaging (including x-ray), diagnostic mammography, and laboratory services, see "Diagnostic Imaging And Laboratory Services" on page 22.

For contraceptive services benefit information, see “Contraceptive Services” on page 21.

For health education services benefit information, see “Health Education” on page 23.

For nutritional therapy services benefit information, see “Nutritional Therapy” on page 28.

“Preventive care benefits *are not* available for:

- Services related to a specific illness, injury or a definitive set of symptoms, (these may be covered under other benefits)
- Vitamins or nutritional supplements
- Dental examinations or treatment, the fitting of dental appliances or dentures, or other services provided by a licensed dentist or denturist
- Services for eye examinations or the fitting of eyeglasses or contacts
- Routine fitness testing, such as aerobic capacity, flexibility, body fat percentage, etc.
- Physical exams for life or disability insurance
- Work-related disability evaluations or medical disability evaluations

Please also see "What’s Not Covered?" for additional limitations and exclusions.

Preventive Screenings

Benefits are provided for preventive screenings including prostate, cervical and colorectal cancer screenings and preventive mammograms as follows:

- **Foundation Providers:** The plan pays 100% of allowable charges; no calendar year deductible
- **Non-Foundation Providers**: After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Prosthetics, Orthotics and Medical Equipment

Benefits are provided for medical equipment, prosthetics and orthotics (including sales tax for covered items) used in direct treatment of a covered illness or injury.

Benefits are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Medical Equipment benefits are provided for rental or purchase of home medical equipment, such as:

- Crutches
- Diabetic equipment such as blood glucose monitor, insulin pumps and accessories to pumps, and insulin infusion devices
- Dialysis equipment
- Hospital-type beds
- Intermittent Positive Pressure Breathing Apparatuses
- Traction equipment
- Ventilators
- Wheelchairs

Benefits are provided for a basic manual wheelchair as a back-up when an enrollee is eligible for a power wheelchair.

Home medical equipment is equipment which can stand repeated use (with the exception of certain consumable medical supplies), and is used in the direct treatment of a covered illness or injury. It is generally not useful to a person in the absence of illness or injury, and is ordered and/or prescribed by a physician.

Benefits are also provided for vision hardware, including contact lenses and eye glass lenses and frames for medical conditions of the eye such as corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjorgren's syndrome, congenital cataract, corneal abrasion and keratoconus.

See "Prescription Drugs" on page 32 for coverage of diabetic testing supplies.

Prosthetics and Orthotics benefits are provided for prosthetics such as:

- Artificial limbs or eyes
- Braces
- Casts
- Splints
- Trusses
- Therapeutic shoes or orthotics for the feet (shoe inserts), including those that are medically necessary to prevent complications associated with chronic peripheral vascular disease. Impression casting for shoe inserts is also provided for covered inserts. Therapeutic shoes or inserts for non-diabetic conditions are limited to $300 per calendar year.

The Prosthetics, Orthotics and Medical Equipment benefit does not cover:

- Supplies or equipment not primarily intended for medical use
- Environmental or building modifications to your home or personal vehicle
- Exercise equipment and weights
- Whirlpool baths, air purifiers, sauna baths, massage devices or personal convenience or comfort items
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Eyeglasses or contact lenses for conditions not listed as a covered medical condition, including routine eye care
- Replacement of medical equipment or prosthetics due to loss, theft or accidental damage
- Over-the-counter braces or cranial banding
- Non-wearable defibrillator
- Trusses
- Ultrasonic nebulizer
- Blood pressure cuffs and monitors
- Enuresis alarms
- Non-prescription compression stockings

Please Note: This benefit does not include prosthetics prescribed or purchased as part of a mastectomy or breast reconstruction. Please see "Mastectomy and Breast Reconstruction" on page 26 for coverage information.

This benefit does not include medical equipment or supplies provided as part of home health care or hospice care. Please see “Home Health Care” on page 23 and “Hospice Care” on page 25 for coverage information.

This benefit does not include prosthetics, intraocular lenses, appliances or devices requiring surgical

implantation. These items are covered as a surgical service under "Surgical And Medical Care (Professional) on page 41. Items provided and billed by a hospital are covered under "Hospital Services" on page 25.

Disposable Medical Supplies benefits are provided for disposable medical supplies such as oxygen, bandages, and colostomy supplies. Disposable diabetic testing supplies are covered under "Prescription Drugs" on page 32.

Psychological and Neuropsychological Testing

Benefits are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Covered services include neurological, psychological and mental health testing and evaluations, including interpretation, necessary to prescribe an appropriate treatment plan. This includes re-evaluations.

- Physical, speech or occupational therapy assessments and evaluations are provided under "Rehabilitative Care" on page 39.
- Physical, speech or occupational therapy assessments related to neurodevelopmental therapy are covered under "Neurodevelopmental Therapy" on page 29.

Rehabilitative Care (Inpatient and Outpatient)

Benefits are provided for inpatient and outpatient rehabilitative care when the criteria specified below is met. This care restores or improves lost bodily functions caused by illness or injury. It could include speech and hearing therapy, physical therapy, massage therapy, cardiopulmonary rehabilitation, rehabilitative counseling and function occupational therapy. Care is given by a licensed or registered therapist and begins within one year of the date the condition began.

Speech and occupational therapy provided for treatment of a mental health condition are provided as part of the mental health benefit. See the “Mental Health/Behavioral Health (Inpatient and Outpatient)” benefit for additional information.

Inpatient Rehabilitative Care

Benefits are provided **up to 30 days per enrollee each calendar year** as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Benefits begin on the day after your treatment becomes primarily rehabilitative. Benefits are provided when treatment is:

- For services that are necessary to restore or improve lost functions due to illness or injury;
- Provided in a legally operated hospital with a specialized rehabilitative care department approved by Premera Blue Cross (call WEA Select Customer Service for a list of approved facilities);
- Part of a continuous inpatient stay following acute treatment. Admissions solely for rehabilitative care are not included for benefits;
- Part of a formal written program of treatment prescribed by a physician; and
- Part of a plan requiring a variety of rehabilitative services.

These benefits continue as long as you are eligible under this plan and need the services of a team of rehabilitative professionals, including a physical therapist, massage practitioner, occupational therapist, speech therapist or a rehabilitation counselor, and as long as these services can only be provided in a hospital.

Outpatient Rehabilitative Care

Benefits are provided for outpatient rehabilitative care **up to 15 visits each calendar year** when you are **not** confined in a hospital. Benefits for covered services are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Benefits are not provided for:

- Social, cultural, and vocational therapy
- Acupressure
- Services provided by employees of a home health agency or hospice

Please see "What's Not Covered?" for additional limitations and exclusions.

Skilled Nursing Facility

For the treatment of a covered medical condition or injury that requires medically necessary skilled care, you are covered at a participating facility **up to 60 days each calendar year** as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Services are limited to:

- A state-licensed skilled nursing facility
- Skilled nursing facility in Alaska that is a preferred or participating provider or
- Medicare-approved skilled nursing facility outside Washington and Alaska that is a preferred provider ("PPO") through the BlueCard Program

When facilities as noted above are used, covered services that are provided and billed by a participating skilled nursing facility include:

- Room, meals and general nursing care
- Routine laboratory examinations
- Physical, occupational, speech and respiratory therapy
- Medical supplies, prescription drugs and blood products

If the services of a participating skilled nursing facility are not available, please call Integrated Health Management at 1-800-932-9221.

Skilled medical care primarily treats an illness or injury with services that can only be furnished by a health care provider with specific medical knowledge and technical training, such as a registered nurse, a physical therapist, a speech therapist or a respiratory therapist. It does *not* include services primarily for ongoing maintenance of the enrollee's health, even if furnished by one of the above-named health care providers.

Examples of skilled medical care include:

- Intramuscular or intravenous administration of medication
- Complex dressing changes
- Monitoring unstable vital signs
- Acute respiratory care
- Physical, occupational and speech therapy

To be covered, skilled nursing facility care cannot be maintenance or custodial care. Care must be:

- Prescribed by your physician
- Require skilled medical care
- "Medically necessary" and not maintenance or custodial care (see "Definitions") and
- Furnished and billed by a skilled nursing facility as defined in this section unless the services are to treat a medical emergency or injury

Note: Benefits may not be provided for every service or supply the physician recommends. We may exclude or limit benefits unless services are both skilled medical care and medically necessary.

In addition to exclusions and limitations in "What's Not Covered?" this benefit does not cover:

- Custodial or maintenance care (see "Definitions")
- Care primarily for senile deterioration, mental deficiency or retardation, psychiatric conditions or chemical dependency
- Services or supplies of a personal nature or for the enrollee's convenience, such as meals for guests; charges for use of radio, television, or telephone; or the services of a barber or beautician

For more information, please call WEA Select Customer Service at 1-800-932-9221.

Spinal Manipulations and Associated Services

Benefits for manipulations of the spine and extremities, including chiropractic manipulations by hand, are provided **up to a maximum of 12 visits** per enrollee each calendar year for all providers combined. Services must be within the scope of the provider's license, and be medically necessary to treat a covered injury, illness or condition.

Benefits are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Benefits for diagnostic imaging (including x-rays) are described on page 22.

Surgical And Medical Care (Professional)

Covered services include surgical and medical care by a physician (diagnosis and treatment of a covered condition, surgery, services of an assistant surgeon and administration of anesthesia) and administration of chemotherapy, x-ray, radium and radioactive isotope therapy, therapeutic and allergy testing/injections as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Coverage will be provided for general anesthesia that is delivered by an anesthesiologist for certain procedures only if it meets medical criteria. For more information contact WEA Select Customer Service.

Facilities charges may apply; please see "Hospital Services (Inpatient and Outpatient)" on page 25 for information on facility cost-shares.

Please see "Office Visits (Office and Home)" on page 31 for physician office calls.

Temporomandibular Joint (TMJ) Disorders

This benefit includes coverage for inpatient hospital and outpatient facility and professional care, including professional visits, for the treatment of temporomandibular joint (TMJ) disorders, as follows:

Non-Surgical Services:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Surgical Services:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Medical services and supplies are those that are:

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

Limitations: These benefits will not be payable for: dental services and supplies such as crowns, bridgework and dentures; training and educational services; holistic therapy; and orthodontic services, except for splints and guard.

Transgender Services

Covered benefits include medically necessary transgender surgical services, including facility and anesthesia charges related to all transgender related surgery, as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Transgender Surgical Services Criteria

Surgical gender reassignment services will be considered medically necessary if the following criteria are met.

For all surgical procedures approved in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), transgender benefits are available if:

1. You are at least 18 years old and diagnosed as having gender identity disorder.
2. For breast surgery (mastectomy, chest reconstruction or augmentation mammoplasty) you must also have one letter of recommendation for surgery from a mental health professional.
3. For genital surgery (examples include: orchiectomy, penectomy, vaginoplasty, clitoroplasty, labiaplasty, hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, testicular prosthesis placement, and phalloplasty) the first criteria listed above and all the following criteria must be met:
    - You have been an active participant in a recognized gender identity treatment program and have successfully lived and worked within the desired gender role full time for at least 12 months.
    - You have received recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. One master’s degree level professional is

acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.

- The surgery is recognized as medically necessary within the most current Standards of Care published by the World Professional Association for Transgender Health WPATH).

Please Note: Coverage of prescription drugs, lab, x-ray and other non-surgical services and mental health treatment associated with the treatment of gender dysphoria is eligible under the general plan provisions subject to the applicable copay, deductible or coinsurance and plan limitations and exclusions.

Obtaining a Prior Authorization

To check on your benefit eligibility, the physician who is the most knowledgeable about your history may submit a prior authorization request to Premera Blue Cross on your behalf. The request should include:

- The surgical procedure(s) for which coverage is being requested
- The date the surgery will be performed
- Information supporting that criteria listed above has been met, based on the surgery being requested

Your physician can fax this information to 1-800-866-4198 or mail it to:

Premera Blue Cross
Attn: Care Facilitation
P.O. Box 91059
Seattle, WA 98111-9159

Transplants

Covered Transplants

Coverage is available *only* when organ, bone marrow and stem cell transplants meet the criteria for benefits and are done in a transplant center (the team of physicians that performs the transplant and the hospital in which it is done) with a Premera Blue Cross contract or is in the special network of transplant centers around the country, as follows:

- Benefits for transplant services are provided on the same basis as any other service, subject to the deductible and coinsurance.

Premera Blue Cross reserves the right to base payment of the written transplant request on all of the following:

1. The type of transplant must not be experimental or investigational (see "Definitions" for experimental/investigational). The type of transplants that currently meet our criteria for coverage are heart, heart/double lung, single lung, double lung, liver, kidney, pancreas, pancreas with kidney, certain autologous and allogeneic bone marrow and stem cell transplants, including hematopoietic stem cell harvesting and infusion, whether harvested from bone marrow, peripheral blood or any other source.

   Please Note: In this plan, the term "transplant" does not include corneal transplants, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). Coverage for these services may be provided under other benefits.
2. The medical condition must meet Premera Blue Cross established criteria.
3. The transplant center must qualify under Premera Blue Cross written standards.

Transplant Services and Supplies

This benefit covers the following services and supplies for covered transplants as outlined below:

- **Recipient Costs:** Benefits are provided for hospitalization, surgery, diagnostic and therapeutic services for an approved transplant. Also included in this benefit are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.
- **Donor Costs:** Evaluation of the donor organ or bone marrow, its removal and transport of both the surgical/harvesting team and donor organ or bone marrow. Inpatient hospital and professional benefits described in this plan will be provided for an organ or bone marrow donor beginning on the day of surgery and continuing for up to 10 additional, consecutive days while the donor remains hospitalized. Also covered are bone marrow testing and typing of the brothers, sisters, parents and children of the enrollee who needs the transplant. Testing and typing of any other potential donor is

only covered when the potential donor meets specific medical criteria. Storage costs for bone marrow and stem cells are limited to a period of up to 12 months.

Transportation and Lodging Expenses

Benefits for transportation and lodging expenses are subject only to your calendar year deductible.

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

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

Exclusions and limitations: This benefit does not include:

- Donor costs if the donor is an enrollee but the recipient is not. However, complications and unforeseen effects from an enrollee's organ or bone marrow donation will be covered as any other illness to the extent not covered under the recipient's coverage.
- Donor costs for which benefits are available under other group or individual coverage.
- Organ or bone marrow search or selection costs (including registry charges) except as named under "Donor Costs" above.
- Non-human or mechanical organs unless we determine they are not experimental or investigational according to the criteria in "Definitions."
- Services or supplies paid for by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Services or supplies furnished in connection with or related to a non-covered organ or bone marrow transplant, including follow-up care and any direct complications, consequences or aftereffects arising from it.
- Transportation, except as named under "Donor Costs" and "Transportation and Lodging Expenses," above, and medically necessary "Ambulance Services" on page 19.
- Meals and lodging except as covered above under "Transportation and Lodging Expenses."
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed. Take-home prescription drugs are covered under "Prescription Drugs" on page 32.

Please also see "What's Not Covered?"

Vision Therapy

Benefits are provided for medically necessary vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye (orthoptics) and pleoptics. Vision therapy does not cover vision perceptive training or therapy. Vision therapy is not subject to the outpatient rehabilitative care benefit maximum. Benefits are provided as follows:

- **Foundation Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Foundation Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

WHAT'S NOT COVERED?

If you have questions or need more information about any of the non-covered or limited services listed below, please contact WEA Select Customer Service at 1-800-932-9221.

NON-COVERED SERVICES

Your plan does *not* cover any services or supplies furnished in connection with the following conditions, services or supplies:

1. Services, supplies and procedures related to altering the refractive character of the cornea and their direct results, including but not limited to, radial keratotomy, corneal modulation, keratomileusis or refractive keratoplasty.
2. Any services or supplies for which no charge is made or would not have been made if this plan were not in effect, or for charges for services or supplies for which you are not legally liable.
3. Services, supplies or drugs for the treatment of caffeine dependency or abuse.
4. Military and war related conditions, including illegal acts. This includes:
    - Acts of war, declared or undeclared, including acts of armed invasion
    - Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy or civilian forces or units auxiliary thereto
    - An enrollee's commission of an act of riot or insurrection
    - An enrollee's commission of a felony (does not apply to a victim of domestic violence) or act of terrorism
5. Services or supplies not medically necessary, even if ordered by a court of law, for treatment of a disease, injury, illness or pregnancy.
6. Any services or supplies not specifically listed as covered benefits.
7. Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage or adoption. Examples of such providers are your spouse, parent or child. Services or supplies provided by volunteers, except as specified in "Home Health Care" on page 23 and "Hospice Care" on page 25.
8. Any service, supply or procedure which is experimental or investigational on the date it is furnished, based on the criteria stated in "Definitions" for experimental/investigational. Also excluded are complications of such services or supplies.

    If it is determined that a service is experimental or investigational and therefore not covered, you may appeal our decision. We will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.
9. Milieu therapy (treatment intended primarily to provide a change in environment or a controlled environment).
10. Private duty nursing.
11. Hair prostheses, such as wigs or hair weaves, transplants, and implants. Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth.
12. Charges from providers for records or reports, except those we request for utilization review.
13. Custodial care. This includes room, board, any other facility services and professional care provided for senile dementia, mental deficiency or retardation, or primarily to assist you with activities of daily living because of a physical or mental condition, or age. See "Definitions."
14. Hearing examinations; hearing aid, new or replacement.
15. Low-level laser therapy for treatment of any diagnosis, including but not limited to vitiligio
16. Donor breast milk (e.g. services of a wet nurse)

LIMITED SERVICES

Your plan does not cover the following, *except* as specifically stated:

1. The plan does not cover services, drugs, or supplies for cosmetic purposes, including any direct or

indirect complications and aftereffects. Examples of what is not covered are:

- Reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body
- Genital surgery for the purpose of changing genital appearance
- Breast mastectomy or augmentation for the purpose of changing the appearance of the breasts, with or without chest reconstruction

The only exceptions to this exclusion are:

- Repair a defect caused by an injury if the services, supplies and procedures are rendered within 12 months of the injury
- Perform reconstructive breast surgery in connection with a mastectomy as provided under "Mastectomy and Breast Reconstruction Services" on page 26
- Repair a dependent child's congenital anomaly (see "Definitions")
- Correction of functional disorders upon our review and approval. This does not include removal of excess skin and or fat related to weight loss surgery or the use of obesity drugs.
- Treat gender dysphoria, as stated under the "Transgender Services" benefit on page 42.

2. Eye refractions, eyeglasses, contact lenses, except as specifically stated, or the fitting of eyeglasses to correct vision.
3. Services or supplies for learning disabilities, except therapy services as stated under "Neurodevelopmental Therapy (Inpatient and Outpatient)" on page 29.
4. Vocational counseling; outreach; job training and other counseling or training services, except as stated under "Health Education" on page 23 and "Chemical Dependency/Behavioral Health Treatment (Inpatient and Outpatient)" on page 20.
5. Services or supplies received in and billed by a non-participating hospital owned or operated by a county, state or federal agency, except:
   - For treatment of a medical emergency
   - As otherwise required by state or federal law

   All services and supplies must be furnished and billed by the hospital.
6. Any services provided by an institution which is primarily a rest home, a home for the aged, a nursing home, a convalescent home or anything similar, except as specifically covered by your plan.
7. Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient facilities, or unless the enrollee's medical condition makes inpatient care medically necessary.
8. Transportation services and devices, except as stated under "Transplants" on page 43 and medically necessary ambulance services as specified on page 19.
9. Routine foot care procedures such as, but not limited to, the trimming of nails, corns or calluses, or routine hygienic care, except when a functional disorder such as redness, swelling, loss of function or infection is present; services and supplies for fallen arches or other symptomatic complaints of the feet; impression casting for prosthetics and appliances (therapeutic shoes or inserts), including prescriptions for them, except as specifically provided in "Prosthetics, Orthotics and Medical Equipment" on page 37.
10. Hospital care for the extraction of teeth or other dental procedures, except as stated on page 22.
11. Services of a licensed dentist (D.M.D. or D.D.S.) or denturist except as specified on page 22; dental services such as extractions, prostheses (bite guards), orthodontia, crowns, fillings and treatment of gingivitis. Benefits will not be provided for injuries caused by biting or chewing. Also excluded are dental implants to replace missing teeth, except as part of medically necessary treatment as described on page 22.
12. Services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain-dysfunction (MPD).
13. Inpatient and outpatient rehabilitative care (including, but not limited to, speech, physical, massage, vision and occupational therapy), except as specified under "Rehabilitative Care (Inpatient and

Outpatient)" on page 39 or “Vision Therapy” on page 44. Benefits also will not be provided for care which, during a period of continuous hospitalization, develops primarily into rehabilitative care, except as specifically provided by the plan.

14. Inpatient and outpatient neurodevelopmental therapy except as specified under "Neurodevelopmental Therapy (Inpatient and Outpatient)" on page 29.
15. Transplants, except as specified on page 43.
16. Treatment for alcohol or drug use, abuse or dependency except as defined and provided in "Chemical Dependency/Behavioral Health Treatment (Inpatient and Outpatient)" on page 20.
17. Services, supplies, drugs and procedures for sexual disorders and dysfunction, whether the consequence of illness, disease or injury, including but not limited to impotence (except as specified) or frigidity.

    Services, supplies, drugs and procedures for fertility enhancement or assistance, infertility or diagnosis or treatment of reproductive disorders regardless of diagnosis or origin of condition. Benefits are not provided for any services, drugs or supplies related to assistive reproductive technology, including, but not limited to, sperm or egg harvesting, storage or banking; in vitro fertilization, artificial insemination, and gamete intrafallopian transplant, and any direct or indirect complications of such procedures. Also excluded is reversal of sterilization.
18. Well-baby care, including physical examinations except as specifically provided under "Preventive Care" on page 36 and under "Newborn Care" on page 30.
19. Treatment of psychiatric conditions, including treatment of eating disorders such as anorexia nervosa, bulimia or any similar conditions except as specified in “Mental Health/Behavioral Health (Inpatient and Outpatient)” on page 27.
20. Services and supplies for which the enrollee is entitled to receive benefits from any federal, state or governmental plan, excluding Medicare, except as otherwise required by law are not covered. This exclusion applies even if a claim was not filed.
21. Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering:
    - Motor vehicle medical, motor vehicle no-fault, or any type of no-fault coverage such as personal injury protection (PIP) coverage, medical payment coverage, or medical premises coverage; or
    - Any type of excess coverage, boat coverage, school or athletic coverage
22. Drugs and medicines, except for drugs and medicines delivered by and administered while confined in a medical facility, or prescription drugs covered under "Retail Pharmacy," on page 32 "Specialty Pharmacy" on page 33, "Mail Order Pharmacy " on page 33, "Home Health Care" on page 23, "Hospice Care" on page 25, "Chemical Dependency/Behavioral Health Treatment (Inpatient and Outpatient)" on page 20, or "Medical Foods" on page 27. Even if prescribed by a physician, this plan does not cover fertility drugs (regardless of their intended use); over-the-counter drugs and supplies except as required by state or federal law or regulation; food supplements; herbal, naturopathic or homeopathic medicines or devices; and vitamins that do not require a prescription. Benefits are not provided for growth hormone treatment of idiopathic short stature without growth hormone deficiency.
23. Home health care except as specified on page 23.
24. Hospice care except as specified on page 25.
25. Services and supplies obtained from providers outside the United States will be covered on the same basis as those same services and supplies obtained in this country. However, they must not be experimental or investigational according to the criteria stated in "Definitions" for experimental/investigational.
26. Biofeedback Services that are deemed experimental or investigational treatment for the condition, such as EEG biofeedback and neurofeedback
27. Nicotine Dependency, except as specified on page 23.
28. Surgical or pharmaceutical treatments for obesity or morbid obesity, and any direct or indirect complications, follow-up services, and aftereffects thereof. This exclusion applies to all surgical obesity procedures (inpatient and outpatient) and all obesity drugs and supplements, even if you also have an illness or injury that might be helped by weight loss. However, if benefits were provided under a WEA Select plan for a surgery for treatment of obesity, including morbid obesity, performed

between October 1, 1986, and September 30, 1990, then benefits will be provided for covered services required to treat complications caused by that surgery.

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

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

    A Never Event is an event that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part, or a wrong surgery.

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

30. Non-Treatment Facilities, Institutions or Programs for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes and juvenile detention facilities. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations.

31. Online consultations including email, non-secure connection, text, instant message and all interactions not specifically outlined in the Telemedicine/Virtual Care benefit page 31.

GENERAL PROVISIONS

CERTIFICATION OF NEED FOR HEALTH CARE SERVICES

We have the right to require proof of medical necessity from an enrollee receiving benefits under this plan. This proof may be submitted by you or on your behalf by providers. No benefits will be available under this plan if the proof is not provided or acceptable to us.

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 released for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting integrated health management, case management or quality reviews, and
- Fulfilling other legal obligations that are specified under the group contract

This information may also be collected, used or released 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 is not related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

With reasonable notice, you may view your medical records at your provider’s office and receive a copy of your records by paying for copying. To make these requests, contact your provider’s office.

TRANSFER OF BENEFITS: ASSIGNMENT, GARNISHMENT AND ATTACHMENT

All benefits are personal and available only to enrollees. They will not be provided for anyone else.

The right to payment under Premera Blue Cross's contract with the WEA is not subject to attachment or garnishment, and Premera Blue Cross will not honor any assignment of it to anyone. In paying for services, Premera Blue Cross may, at its option, make the payment to the enrollee, the participating employee group, the provider, another carrier or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such remittance shall discharge Premera Blue Cross to the extent of the amount remitted so that it shall not be liable to anyone aggrieved by its choice of payee.

RIGHT OF RECOVERY

This plan has the right, upon demand, to recover overpayments or payments obtained through fraud, error, mistake or payments made in excess of the maximum amount necessary to satisfy the intent of the Coordination of Benefits provision (refer to "What If I Have Other Coverage?"), made to the enrollee, provider, other insurers, any service plans, any other organization, or on behalf of an enrollee or someone who is not eligible to receive benefits.

If reimbursement is not made, such overpayments or payments will be deducted from future payments.

FRAUDULENT CLAIMS

If the enrollee claims benefits for which no care, service or supply is received, the claim will be denied.

VENUE

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

- Within three years of the date we denied in writing the rights claimed under this plan or of the completion date of the independent review process, if applicable, and
- In the State of Washington or the state in which you reside or are employed

All suits or legal proceedings brought by us will be filed within the appropriate statutory period of limitation. In all suits or legal proceedings brought by us venue may lay in King County, State of Washington.

NOTICE OF OTHER COVERAGE

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

- Any legal action or claim against another party for a condition or injury for which we paid benefits and the name and address of that party's insurance carrier
- The name and address of any insurance carrier providing personal injury protection (PIP) underinsured motorist, uninsured motorist or any other insurance under which you are or may be entitled to recover compensation
- The name of any other group insurance plan(s) under which you are covered

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER PLANS (COB)

Important Note: Tax-deductible contributions to a health savings account are only allowed when you are also enrolled in a qualified high deductible health plan. **If in addition to this plan you have other health coverage that is not a qualified high deductible health plan, contributions to an HSA are not allowed.** Contact a tax advisor or HSA plan administrator for more information.

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

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

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

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

Definitions

For the purposes of COB:

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

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

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

Primary And Secondary Rules

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

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

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

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

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

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

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

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

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

Length Of Coverage The plan that covered you longer is primary to the plan that didn't cover you as long.

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

COB's Effect On Benefits

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

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

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

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

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

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

For questions about COB, please contact WEA Select Customer Service at 1-800-932-9221 or the Washington Insurance Department.

EFFECT OF MEDICARE

If the employer is subject to federal "working aged" laws, this plan provides benefits as primary over Medicare for covered, active employees or their covered spouses who are 65 or older and have elected primary coverage under this plan.

This plan also provides benefits as primary over Medicare to the extent that an employer-sponsored health care plan is required to do so by federal law for enrollees who are entitled to Medicare because of a kidney transplant or renal dialysis, and for covered active employees or their dependents when the employee or dependent is under age 65, disabled and covered by Medicare.

DUAL WEA COVERAGE

There is no dual WEA coverage.

SUBROGATION AND REIMBURSEMENT

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

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.

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

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

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

WHO IS ELIGIBLE FOR COVERAGE, AND WHEN?

EMPLOYEE COVERAGE

You are eligible if you are a WEA member who works at least 17.5 hours a week in any division of the Washington Public Schools or the WEA and its Affiliates. If your participating employee group contributes toward the cost of the plan's coverage, the WEA membership and 17.5 hours per week requirements will be waived.

To remain eligible during a school year, a senior substitute teacher must stay in the substitute pool and remain classified as a substitute or regular teacher as defined by the district.

School board members are not eligible for coverage unless they are paid employees of the school district and meet the standard WEA eligibility requirements. School board members who receive compensation for their services as board members are not considered employees for this purpose.

Eligible employees must enroll within 30 days of their effective date or at the annual open enrollment period. Please see your school district administrator for enrollment information.

Coverage begins on the first of the month coinciding with the benefits effective date, provided the subscription charges are remitted on a timely basis. Please see “Loss Of Other Coverage” if you are

coming onto the WEA plan from other coverage.

An employee may only be enrolled as a subscriber in a WEA Select Medical Plan through one school district.

Age 65/Continuing Employment As An Active Employee

If you are either an active employee or an active employee's covered spouse and are age 65 or over, the WEA Select Medical plan will provide primary coverage and if you have Medicare coverage will be secondary.

DEPENDENT COVERAGE

Dependents have the same effective date as you (except if acquired after the effective date), provided you have completed the enrollment process. Eligible dependents are:

- The lawful spouse of the subscriber. ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction.)
- The domestic partner of the subscriber whose partnership with the subscriber is documented in a state domestic partnership registry.

  Please Note: Domestic partnerships that are **not** documented in a state registry must meet all requirements as stated in the signed "WEA Select Health Plans Declaration of Domestic Partnership." To obtain a copy of this form, please visit www.premera.com/wea and click on Enrollee Services tab, then Forms.
- Dependent children under 26 years of age. ("Children" includes the subscriber's or spouse's natural child, adopted child or child placed with the subscriber in accordance with state law for the purpose of legal adoption. "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 physical, mental or developmental disability is an eligible dependent when all of the following requirements are met:
  - The child is incapable of self-sustaining employment due to a developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance.
  - You complete a Request for Certification of Handicapped Dependent form (call WEA Select Customer Service for the form.) We must approve the request for certification. If you are requesting continuation of coverage for a disabled child past age 26, you must provide the certification form to us within 31 days of the child reaching the limiting age. **An overage disabled child who is enrolling on the same date as you are also requires our approval.** You must provide proof of continuous group coverage for the disabled dependent. **Please Note:** You and the disabled child must maintain concurrent coverage under this plan.
  - You provide us with proof of the child's disability and dependent status when we request it. We will not ask for proof more often than once a year after the two-year period following the child's 26th birthday.
- A legally placed ward of you or your 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 note that once enrolled, coverage for dependents may only be dropped at open enrollment, or when there is a qualifying event as described under "Special Enrollment."

Verifying Dependents

The WEA verifies the eligibility of all dependents and reserves the right to request documents from enrollees that substantiate that the person(s) enrolled meet the criteria of the plan. Examples of documents that may be requested include, but are not limited to, government-issued marriage certificates, the Affidavit of Domestic Partnership, government-issued birth certificates and legal guardianship papers. If documents are not provided that verify your dependents' eligibility, their coverage will be canceled and COBRA will not be offered. The WEA Select Medical Plan will not reenroll dependents for whom you are unable to provide acceptable documentation.

Marriage

You may enroll a newly acquired spouse and children within 60 days of marriage. When enrollment is completed within 60 days of the marriage and payment of any required subscription charges has been received, coverage will begin on the first day of the month following the date of the event. If you do not enroll your spouse/children within the specified time period, they may not be enrolled until the next open enrollment period, unless there is a qualifying event. Please see "Open Enrollment" later in this section.

Natural Newborn Children

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To extend the child's coverage beyond the 3-week period or if the mother isn't eligible for obstetrical care benefits under this plan but the child qualifies as an eligible dependent, the subscriber should complete the enrollment as noted below. Coverage becomes effective from the date of birth, unless stated otherwise.

- If you already pay subscription charges for dependent children, please contact the WEA Select Benefits Center to add your dependent. **If notification is not received within 60 days of the date of birth, coverage will become effective on the first of the month following the date of notification.**
- If an additional subscription charge is required to enroll a dependent child, please complete the enrollment process within 60 days following the date of birth. Subscription charges apply as of the first billing cycle following the date of birth. If enrollment is not completed within 60 days of birth, please see "Open Enrollment" later in this section.

Adoptive Children

The subscriber should follow the steps below to enroll the adoptive child from date of placement.

- If you already pay subscription charges for dependent children, please contact the WEA Select Benefits Center to add your dependent child. Coverage becomes effective for adoptive children on the date of placement with the subscriber. **If we don't receive notification within 60 days of the date of placement, coverage will become effective on the first of the month following the date we receive notification.**
- When subscription charges being paid don't already include coverage for dependent children, you must complete the enrollment process within 60 days following the date of placement with the subscriber. Coverage becomes effective from the date of placement. The additional subscription charge will begin on the first billing cycle following date of placement. If you don't complete the enrollment within 60 days of the date of placement with the subscriber, the next opportunity to enroll the adoptive child will be at open enrollment. Please see "Open Enrollment" later in this section.

Legal Guardianship/Non-Parental Custody

Children under legal guardianship (legal wards) or under a legal non-parental custody decree may be enrolled for coverage if the following conditions are met:

- The legal guardianship/non-parental custody was awarded in accordance with the laws of the state in which it was obtained. Documentation must be provided, including the court order and petition for guardianship/non-parental custody, stating the reason and authority of the guardianship/non-parental custody. When the court order terminates or expires, the child is no longer an eligible child.
- The guardian/person with non-parental custody is either you or your spouse. The guardian/person with non-parental custody and the child must both be enrolled under the same plan.
- The child is under 26 years of age.

When you complete the enrollment process for an eligible child covered under legal guardianship (legal wards) or under a legal non-parental custody decree within 60 days of the date of that decree, coverage required under the decree will become effective on the date of the decree.

If enrollment is not completed within the 60-day time period for eligibility, the child/spouse may not enroll until the next open enrollment period. The only exception is explained under "Loss Of Other Coverage."

Medical Child Support Orders

When a child is to be added to your coverage due to a medical child support order, you must provide a copy of the court order (or National Medical Support Notice, Part A or Part B) to the WEA Select Benefit Center. Once approved, coverage for the eligible child required under the order becomes effective on your coverage as of the date of the notice.

Surviving Dependents

If you die, the medical coverage under this plan will continue for enrolled surviving dependent(s) without a subscription charge for up to 12 months following your death. This coverage will only be provided for dependents who were enrolled under this plan at the time of your death and will be subject to the Coordination of Benefits provision stated in this benefit booklet. The school district’s business or payroll office must be notified of this information within 30 days. This 12-month period will apply toward the COBRA continuation period, if elected, and will not extend any other continuation benefits your employer may offer.

Dependents must continue to meet the eligibility requirements as defined under "Who is Eligible for Coverage and When?" Surviving dependents who become ineligible for coverage during the 12-month extension of benefits following the subscriber’s death may apply for COBRA and the monthly subscription charge waiver will no longer apply.

CHANGE IN DEPENDENT STATUS

Please report any changes immediately. Eligibility and subscription charges will not be credited beyond 60 days prior to the date you report a change. Premera Blue Cross will have the right to recover any benefits paid in error.

When a covered dependent is no longer eligible on your medical group coverage, he or she may continue health care coverage on a Premera Blue Cross individual plan or through COBRA; see "How Do I Continue Coverage?"

LOSS OF OTHER COVERAGE

You and your dependents may enroll on this plan or transfer to another WEA plan outside the open enrollment period if you had other health care coverage at the time this plan was offered, but later lost it. The loss of the other coverage *must* be due to one of the following events:

- Loss of eligibility for coverage for reasons including, but not limited to, divorce, death, end of employment, retirement, a reduction in the number of hours employed, or reaching a non-WEA Select health care plan's overall lifetime benefit maximum.
- The employer terminates its contribution toward the coverage, or
- You were covered under COBRA and that COBRA coverage on a non-WEA Select Plan has been exhausted

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

If you or your dependents lose coverage for any other reason, you will have to wait until the next open enrollment period to enroll.

When enrollment is completed within 60 days of the date the prior coverage ended, and payment of any required subscription charges has been received, coverage on the plan will begin on the first of the month after the loss of other coverage.

Please also see "Plan Transfers” and “Special Enrollments."

ENROLLMENT PERIODS

In addition to the criteria described in sections above, the following enrollments may be available.

Open Enrollment

If the school district offers employees a choice of another medical care plan, subscribers and dependents enrolled on the participating employee group's other plan may transfer to this plan during the participating employee group's scheduled open enrollment period.

Eligible employees and/or dependents who are not enrolled on this medical plan or any other medical plan offered by the participating employee group may be enrolled during their scheduled open enrollment period, except as described below.

Enrollment at any other time will be allowed *only* as explained under "Loss Of Other Coverage," "Marriage," "Natural Newborn Children," "Adoptive Children," "Legal Guardianship/Non-parental Custody," "Medical Child Support Orders," or " Special Enrollment."

Special Enrollment

You and your dependents may enroll on this plan or transfer to another school-district sponsored health plan outside the open enrollment period when you are enrolling a new dependent acquired through marriage, birth, adoption, assumption of legal guardianship, non-parental custody or due to a medical child support order as described earlier in this section.

You may choose to enroll without enrolling any eligible dependents.

For information on enrollment procedures and coverage effective dates, please see the appropriate benefit booklet section (Marriage, Natural Newborn Children, Adoptive Children, Legal Guardianship/Non-Parental Custody or Medical Child Support Orders.)

In addition to the above special enrollment rights, you also may be eligible to change your plan, or drop or add dependent coverage if you experience certain qualifying events. Qualifying events include a change in legal marital status, change in employment status of you or your enrolled dependent, change in dependent eligibility (such as reaching the limiting age) or a significant change in the cost of benefits for the employee or dependent. Contact the WEA Select Benefits Center for more information.

Medical Assistance And Children's Health Insurance Program

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

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

To be covered, the eligible employee or dependent must enroll and any required subscription charges must be paid no more than 60 days from the date any of the above conditions are met. Coverage will start on the first of the month following the date you complete the enrollment process for coverage. An eligible employee who elected not to enroll in this plan when such coverage was previously offered must enroll in this plan in order for any otherwise eligible dependents to be enrolled in accordance with this provision. Coverage for the employee will start on the date the dependent's coverage starts. You may be asked to provide the notice of eligibility you received from DSHS.

CONTINUED ENROLLMENT: SELF-PAY PROVISIONS

Leave Of Absence

Coverage for you and any enrolled dependents on an official leave of absence or sabbatical may continue for up to 18 months. The leave of absence time period must begin at the end of the last month of coverage paid from fringe benefit funds earned during active employment. If you do not elect continued coverage at this time, or if you terminate coverage at any time during the leave of absence, you must re-enroll on the plan within 30 days of your return to active employment. If you do not elect coverage under the leave of absence provision, or terminate coverage during the leave, you will immediately become eligible for COBRA. To be eligible for COBRA, you must elect coverage under COBRA within 60 days

after coverage ends under the leave of absence provision.

A district-approved leave beyond 18 months does not entitle you (or your enrolled dependents) to extend coverage under this leave of absence provision. If you do not return to work after the leave or if another consecutive district-approved leave is granted without another period of active employment, you and your enrolled dependents may be eligible for an additional 18 months of continued coverage through COBRA (see below).

The maximum period of extended coverage under any circumstance is 36 months, i.e., up to 18 months of continued coverage under the leave of absence provision and up to 18 months of COBRA continuation coverage.

Additional coverage under this provision may be elected if you return to work and are granted further official leaves of absence or sabbaticals.

Example:

- You are granted a leave of absence and are no longer actively at work as of March 20
- Your active work results in fringe benefit dollars for March, which pay for April benefits
- You will receive sick leave through the district leave-sharing plan for 2 months

In the above example, the 18-month leave of absence coverage period would officially begin on May 1, because April is the last month of fringe benefit funds from active employment. The total extended coverage for sick leave and the leave of absence would be 18 months, at which time the district would need to provide you notice of access to COBRA continuation for 18 additional months (total 36 months). If the above leave of absence started before the March payroll cutoff for benefits, the leave period would begin April 1.

Dependents can only be added during a leave of absence period when they qualify to enroll as stated under "Enrollment Periods." For more information, please see "Enrollment Periods."

Family Medical Leave

Employer-paid continuation of coverage may be available in the event of leave as specified in federal and state legislation. Timeframes and circumstances may vary. Please check with the school district's payroll office for more information.

Labor Dispute

If compensation is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may pay subscription charges for yourself and eligible dependents directly to the employer for up to six months. See "How Do I Continue Coverage?" and "Converting To A Different Plan" for continued health care coverage when the six-month period ends. This period of coverage will not extend any other period of continued coverage provided by the plan.

When your compensation or wage is suspended or terminated, you will be notified immediately in writing by your participating employee group. A notice will be mailed to the address last on record with your participating employee group that you may pay subscription charges to the participating employee group as noted in this section.

Reduction In Force (for employee groups with less than 20 employees)

For those participating employee groups who do not provide "COBRA" this plan may be continued on a self-paid basis through the group for up to 12 months from the date of lay-off.

HOW DO I CONTINUE COVERAGE?

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.

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

COBRA Continuation Of Group Coverage (for participating employee groups with 20 or more employees)

When group coverage is lost because of a "qualifying event" outlined below, federal laws and regulations require the participating employee group to offer an election to continue the group coverage for a limited time. (These laws and regulations are referred to in this plan as "COBRA.") Continued coverage is not automatic. Under COBRA, a qualified enrollee must apply for continued coverage within a certain time period and may also have to pay the subscription charges for it.

The participating employee group must fulfill all of the obligations and responsibilities regarding continued coverage that are assigned by COBRA to the participating employee group, plan sponsor or administrator, and to the group health plan. Premera Blue Cross is not the COBRA plan administrator, and our actions pertaining to COBRA continued coverage under this contract shall not be construed as relieving the participating employee group of its responsibility under COBRA. We provide coverage only to the extent that enrollees are entitled to continued coverage under COBRA and only to the extent of the other terms and limitations of this contract.

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

Qualifying Events and Length of Coverage: Please contact the participating employee group immediately when one of the qualifying events below occurs. The continuation periods listed extend from the date of the qualifying event.

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

- The participating employee group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if coverage is lost because of one of two qualifying events:
  - The subscriber's work hours are reduced
  - The subscriber's employment terminates, except for discharge due to actions defined by the participating employee 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 participating employee 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 an enrollee who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The participating employee 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 one of four qualifying events:
  - The subscriber dies
  - The subscriber and spouse 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 Continued Coverage: For continued 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.

You or your affected dependent must notify the group in the event of a divorce or child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in "Qualifying Events And Lengths Of Coverage." You or your affected dependent must also notify the group if the Social Security Administration determines that you or your 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 enrollee loses the right to COBRA coverage. Except as described below for disability notices, you or your 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 your termination or reduction in hours; 2) the date qualified enrollee would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please note: Determinations that a qualified enrollee is disabled must be given to the group before the 18-month continuation period ends. This means that the subscriber or qualified enrollee 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: You or your affected dependent must also notify the group if a qualified enrollee 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 enrollee 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 are informed by the group.

The group must notify qualified enrollees of their rights under COBRA. If the group has named a third party as its plan administrator, the plan administrator is responsible to notify enrollees 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 enrollee as stated above) in which to notify qualified enrollees 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

- The enrollee must elect continued 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 the participating employee group notified the enrollee of his or her right to elect continued coverage.

  Each qualified enrollee 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.

- The enrollee must send the first subscription charge payment to the participating employee group no more than 45 days after the date the person elected continued coverage.
- Subsequent subscription charges must be paid on a timely basis to the participating employee group and submitted with the participating employee group's regular monthly billings.

Adding Family Members

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

Keep the participating employee group informed of address changes

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

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

- The applicable continuation period expires.
- The next monthly subscription charge is not paid when due or within the grace period.
- If the enrollee has extended COBRA coverage due to disability, it will end if Social Security determines that the person is no longer disabled. In this case, coverage terminates at the end of the month that begins at least 30 days after Social Security's decision. For example, if Social Security decides on March 15 that the enrollee is not disabled, coverage would end May 31. The enrollee must provide the participating employee group a copy of the determination within 30 days after the **later** of: 1) date of the determination or 2) the date on which you or your affected dependent was informed that this notice should be provided and given procedures to follow.
- The enrollee becomes covered under another group health care plan after the date COBRA coverage was elected. If, however, the new plan contains an exclusion or limitation for a pre-existing condition, coverage does not end for this reason until the exclusion or limitation no longer applies.
- The enrollee becomes entitled to Medicare after the date COBRA coverage was elected.
- The participating employee group ceases to offer this WEA Select Medical plan to any employee in the bargaining unit/employee classification. However, the enrollee should contact the participating employee group regarding participation in any other group health plan offered to the bargaining unit/employee classification.

However, even if one of the events above has not occurred, continued coverage under this plan will end on the date that the contract between the WEA and Premera Blue Cross is cancelled.

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 web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.

Converting To A Different Plan

When coverage under this group plan ends (either active coverage or through COBRA), the enrollee may

enroll on individual or Medicare Supplement coverage.

Individual Coverage

Once your group coverage ends, you may be eligible to enroll in an individual plan through Premera Blue Cross. Enrollment is subject to specific time periods. Contact WEA Select Customer Service for details.

You also may be eligible for individual coverage through the Washington Healthplanfinder. Contact them at 1-855-923-4633 or www.wahealthplanfider.org.

Medicare Supplement Coverage

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, some people *may* be eligible for guaranteed-issue coverage under certain Medicare supplement plans if they apply within 63 days of losing coverage under this plan.

When You Retire

Besides the above options, plans are available to school district retirees through the Public Employees Benefits Board (PEBB), administered by the Washington Health Care Authority (HCA). Call 1-800-200-1004 for eligibility information for PEBB sponsored plans.

WHEN WILL MY COVERAGE END?

RIGHTS TO BENEFITS AFTER TERMINATION

Benefits are not provided for services, treatment, medical attention or care that an enrollee received after his or her coverage terminated or the contract terminated.

No rights are vested under this plan.

EVENTS THAT END COVERAGE

Coverage for the subscriber and all dependents under this medical plan will stop at the end of the period for which the appropriate subscription charges were paid, or if one of the following occurs:

Subscriber And Dependents:

- The subscriber ceases to meet the eligibility requirements
  - The subscriber goes beyond an approved leave of absence or sabbatical
  - The subscriber is no longer employed by or connected with the participating employee group, or the participating employee group no longer participates in this plan
  - The next monthly subscription charge is not paid when due or within the grace period
  - The contract between the WEA and Premera Blue Cross is cancelled

Spouse:

- The marriage to the subscriber terminates due to divorce or annulment.
- The subscriber dies or is no longer covered under this plan. (See "Coverage For Surviving Dependents")

Dependent Child(ren):

- Reaches the age of 26 (unless developmentally disabled or physically handicapped—see "Dependent Coverage”)
- The subscriber dies or is no longer covered under this plan. (See "Coverage For Surviving Dependents")

If the subscriber is no longer employed by or eligible for coverage with the participating employee group or a family member is no longer eligible, medical coverage will be cancelled automatically without notice at the end of the period for which subscription charges have been appropriately paid. **Refunds will not**

exceed more than 60 days worth of subscription charges, based on the date a change is reported to us. See "How Do I Continue Coverage?" and "Converting To A Different Plan" for continued health care benefits.

PLAN TRANSFERS

Transfer Provision: If the participating employee group offers employees a choice of another WEA Select health care plan with Premera Blue Cross, the participating employee group may allow subscribers and their enrolled dependents to transfer coverage from one plan to another during an open enrollment period for this plan, or on another date designated by Premera Blue Cross. Transfers may also occur if the participating employee group replaces a WEA Select health care plan with another WEA Select health care plan.

When someone transfers from one WEA Select plan to another, amounts credited toward applicable calendar year deductibles, coinsurance maximum or benefit maximums under the other plan will also apply to this one's applicable coinsurance and benefit maximums. Annual benefit maximums met in one calendar year will not be credited to a subsequent calendar year. Please Note: Only calendar year deductibles met during the current calendar year will be credited toward the new plan. Deductible amounts carried over from a previous calendar year are not credited.

HMO Option: Employees who have elected coverage through an HMO offered by the participating employee group may change coverage and enroll under this plan only during an open enrollment period which is approved by Premera Blue Cross, or if they move outside of the HMO service area.

Contract Replacement: When the contract, of which this plan is a part, replaces another contract between the WEA and Premera Blue Cross with no lapse in coverage amounts credited toward the coinsurance maximum or benefit maximums under the other plan will also apply to this plan's applicable coinsurance maximum or benefit maximums.

COMPLAINTS AND APPEALS

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

If you need an interpreter to help with oral translation, please call us at 1-800-932-9221. WEA Select Customer Service will be able to guide you through the service.

WHEN YOU HAVE IDEAS

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

WHEN YOU HAVE QUESTIONS

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

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

WHEN YOU HAVE A COMPLAINT

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

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

WHEN YOU DO NOT AGREE WITH A PAYMENT OR BENEFIT DECISION

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

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

What is an adverse benefit determination?

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

- An enrollee's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits.
- A clinical review decision
- A decision that a service is experimental, investigational, not medically necessary or appropriate, or not effective.

WHEN YOU HAVE AN APPEAL

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

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

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

Who may file an internal appeal?

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

Please call us for an Authorization For Appeal form. You can also get a copy of this form on www.premera.com/wea.

How do I file an internal appeal?

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

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

You may send your written appeal request to:

Premera Blue Cross

Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202
Fax: 1-425-918-5592

If you need help filing an appeal, or would like a copy of the appeals process, please call WEA Select Customer Service at 1-800-932-9221. You can also get a description of the appeals process by visiting www.premera.com/wea.

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

What if my situation is clinically urgent?

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

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

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements. Please call WEA Select Customer Service at 1-800-932-9221 if you want to expedite your appeal.

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

Can I provide more information for my appeal?

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

Can I get copies of information relevant to my appeal?

In your appeal request, you can ask for copies of information relevant to the adverse benefit determination. We will provide this information, as well as any new or additional information we considered, relied upon or generated in connection to your appeal. We will send it as soon as possible and free of charge. You will have the chance to review it and respond to us before we make our decision.

What happens next?

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

- For expedited appeals, as soon as possible, but no later than 72 hours after we received your request. We will call, fax or email and then follow up in writing.
- For appeals for benefit decisions made before you receive the services (prior authorizations), within 14 days of the date we received your request.
- For experimental and investigational appeals, within 20 days of the date we got your request.
- For all other appeals, within 14 days of the date we received your request. If we need more time to review your request, we may extend the review to no more than 30 days, unless we ask for and receive your agreement for more time after the 30 days.

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

Appeals about ongoing care

If you appeal a decision to change, reduce or end coverage of ongoing care because the service is no longer medically necessary or appropriate, we will suspend our denial of benefits during the appeal

period. Our provision of benefits for services received during the internal appeal period does not, and should not be assumed to, reverse our denial. If our decision is upheld, you must repay us all amounts that we paid for such services. You will also be responsible for any difference between our allowable charge and the provider's billed charge if the provider is non-contracting

When Am I Eligible For External Review?

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

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

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

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

When the IRO completes the external review

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

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

What Happens Next?

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

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

Other Resources to help you

If you have questions about understanding a denial of a claim or your appeal rights, you may contact WEA Select Customer Service at 1-800-932-9221. If you want to make a complaint or need help filing an appeal, you can also contact the Washington Consumer Assistance Program at any time during this process.

Washington Consumer Assistance Program

5000 Capitol Blvd.

Tumwater, WA 98501

1-800-562-6900

E-mail: cap@oic.wa.gov

ADDITIONAL INFORMATION ABOUT YOUR COVERAGE

Your benefit booklet provides you with detailed information about your plan's benefits, limitations and

exclusions, how to obtain care, and how to appeal our decisions.

You may also ask for the following information:

- Your right to seek and pay for care outside of your plan
- The preferred drug list, also called a "formulary"
- How we pay providers
- How providers' payment methods help promote good patient care
- A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day or dollar benefit maximums or other overall limitations
- How to file a complaint and a copy of our process for resolving complaints
- How to access specialists
- Accreditation by national managed care organizations
- Use of the health employer data information set (HEDIS) to track performance

If you would like to receive this information, please go to our web site at www.premera.com/wea or call WEA Select Customer Service at:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

DEFINITIONS

Below are terms used in this benefit booklet.

Affordable Care Act The Patient Protection and Affordable Care Act of 2010 (PPACA-Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

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

- **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 will be responsible only for any applicable 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 deductibles, coinsurance, copays and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

- **Providers Outside Washington and Alaska Who Have Agreements With Other Blue Cross Blue Shield licensees**

  The allowable charge is determined as stated in "The BlueCard Program."

- **Providers Who Do Not Have Agreements With Us Or Another Blue Cross Blue Shield licensee**

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

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

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

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

- **Dialysis Due To End Stage Renal Disease**

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

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

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

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

  The amount we pay for dialysis after Medicare's waiting period is the Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

  See the "Dialysis" benefit for more details.

  Emergency Services

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

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

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

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

Ancillary Services Services such as special rooms, supplies, drugs, dressings and laboratory tests you may receive when you are in the hospital or a skilled nursing facility.

Assistant Surgeon The service of an assistant physician when required by regulation or medical necessity.

Congenital Anomaly A marked difference from the normal structure of an infant's body part that's present from birth and manifest during infancy.

Cost-share The member's share of the allowable charge for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See "What Are My Benefits" to find out what your cost-share is.

Custodial Care Any portion of a service, procedure or supply which is provided primarily:

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

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

Effective Date The date on which the enrollee's coverage starts under this plan. This date is established by, and appears on the records of, Premera Blue Cross. If an enrollee's coverage lapses and is reinstated, the enrollee's reinstatement date will be the new effective date.

Emergency Care

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service, routinely available to the emergency department.
- Further medical examination and treatment to stabilize the enrollee to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the enrollee from a medical facility.

Enrollee The subscriber or any eligible dependent enrolled for coverage under this plan.

Essential Health Benefits Benefits defined by the Secretary of Health and Human Services that will include at least the following general categories: ambulatory patient services, emergency care, hospitalization, maternity and newborn care, mental health and chemical dependency services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care. The designation of benefits as essential will be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Exclusion A provision that states Premera Blue Cross has no obligation under this plan to provide any benefits.

Experimental/Investigational Services Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply which meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date the service is provided.
- The service is subject to oversight by an institutional review board.
- No reliable evidence demonstrates the safety and efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management, or treatment.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

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

The documentation used to establish our criteria will be made available for your examination at our office, if you send us a written request.

Health Care Facility Any legally operated hospital, skilled nursing facility, approved treatment facility, which are defined elsewhere in this booklet. These are also referred to as "facilities."

Health Care Provider Any physician or other covered provider of service or facility that treats or provides a service to patients; also called "provider."

Hospital A legally operated hospital:

- Is licensed; and
- For compensation from its patients and on an inpatient basis is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or ill persons by or under the supervision of a staff of physicians, and continuously provides 24-hour-a-day nursing service by or under the supervision of registered nurses; or

- Is any other licensed institution with which the plan has an agreement to render hospital services.

The following are not considered hospitals: residential treatment facilities; skilled nursing facilities; nursing homes; convalescent homes; custodial homes; health resorts; hospices; places for rest; places for the aged; places solely for the treatment of drug abuse and/or alcoholism; and places for the treatment of pulmonary tuberculosis.

Please Note: Services and supplies provided by a hospital owned or operated by a county, state or federal agency are not covered, except for services furnished and billed by a hospital for a medical emergency or as otherwise required by state or federal law.

Injury Physical harm or disability sustained by the enrollee which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. The injury must have occurred at an identifiable time and place. Injuries do not include illness or infection, except infection of a cut or wound resulting from an accident.

Inpatient A hospital-registered inpatient for whom the hospital makes a daily room charge.

Medical Emergency A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medically Necessary Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Mental Health Conditions A condition listed in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse.

Orthodontia That branch of dentistry which deals with the development, prevention and correction of irregularities of the teeth and bite (malocclusion). Malocclusion is the abnormal position and contact of the upper and lower teeth which may affect chewing or cause facial, jaw and/or joint pain.

Physical Therapy Physical therapy is performed for the preservation, enhancement, or restoration of movement and physical function that is impaired or threatened by disability, injury, or disease. It utilizes therapeutic exercise, physical modalities, assistive devices, and patient education and training. Also known as physiotherapy.

Physician One of the following who is licensed to provide medical services in the state where they were received:

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

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

Prescription Drug Any medical substance (including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS) the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
  - **The American Hospital Formulary Service-Drug Information**
  - **The American Medical Association Drug Evaluation**
  - **The United States Pharmacopoeia-Drug Information**
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Provider A licensed or certified individual regulated under Title 18 or Chapter 70.127 RCW or Title 246 WAC to practice health care services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045, and only to the extent services are covered under this contract.

Provider also includes certain health care facilities and other providers of health care services and supplies as stated in this contract. Health care facilities owned or operated by government entities are included as required by state and federal law.

Please Note: Benefits for some types of services furnished by the provider categories included in the definition of "provider" listed above may be limited or excluded under this plan. For further details, please refer to the appropriate sections of this plan booklet or call WEA Select Customer Service at:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

Subscriber The employee who is enrolled on this medical care plan. The employee and dependents enrolled for coverage are also referred to as "enrollees."

Subscription Charges The monthly rates established by us as consideration for the benefits offered in this contract.

Temporomandibular Joint (TMJ) Dysfunction A disorder of the joint which connects the mandible or jawbone to the temporal bone and is generally characterized by pain or muscle spasms in the face, jaw, neck, head, ears, throat and/or shoulders; popping or clicking of the jaw; limited jaw movement or locking; malocclusion; overbite or underbite; and/or mastication (chewing) difficulties.

Washington Education Association

Your Group Life and Accidental Death and
Dismemberment Plan

Policy 603254 011
Group 001 (Life with Medical – Active Employees)

Underwritten by Unum Life Insurance Company of America

11/01/2015

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in easy to understand terms. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to WEA), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at WEA's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

WEA'S ORIGINAL PLAN EFFECTIVE DATE: November 1, 2013

IDENTIFICATION NUMBER: 603254 011

ELIGIBLE GROUP(S):

All eligible employees, in active employment in the United States with an Employer, who are a covered subscriber on the WEA Select Medical Plan, Premera Blue Cross

WAITING PERIOD:

For employees in an eligible group on or before November 1, 2015: First of the month coincident with or next following date of active employment

For employees entering an eligible group after November 1, 2015: First of the month coincident with or next following date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$12,500

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

On the first day of the month following the date you have reached age 65, but not age 70, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 65 ($8,125); or
- 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70 ($8,125).

There will be no further increases in your amount of life insurance.

On the first day of the month following the date you have reached age 70 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction (6,250); or
- 50% of the amount of life insurance shown above if you become insured on or after age 70 ($6,250).

There will be no further increases in your amount of life insurance.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

Premium Waiver

The above items are only highlights of this plan. For a full description of your coverage, please refer to the full certificate of coverage on Premera Blue Cross' web site: www.premera.com/wea, or you may request a copy by calling Aon Hewitt at (206) 467-4646.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

WEA'S ORIGINAL PLAN EFFECTIVE DATE: November 1, 2013

IDENTIFICATION NUMBER: 603254 011

ELIGIBLE GROUP(S):

All eligible employees, in active employment in the United States with an Employer, who are a covered subscriber on the WEA Select Medical Plan, Premera Blue Cross

WAITING PERIOD:

For employees in an eligible group on or before November 1, 2015: First of the month coincident with or next following date of active employment

For employees entering an eligible group after November 1, 2015: First of the month coincident with or next following date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

$12,500

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

On the first day of the month following the date you have reached age 65, but not age 70, your amount of AD&D insurance will be:
- 65% of the amount of AD&D insurance you had prior to age 65 ($8,125); or
- 65% of the amount of AD&D insurance shown above if you become insured on or after age 65 but before age 70 ($8,125).

There will be no further increases in your amount of AD&D insurance.

On the first day of the month following the date you have reached age 70 or more, your amount of AD&D insurance will be:

- 50% of the amount of AD&D insurance you had prior to your first reduction ($6,250); or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 70 ($6,250).

There will be no further increases in your amount of AD&D insurance.

Covered Losses	Benefit Amounts
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
Hemiplegia	The Full Amount
Paraplegia	The Full Amount
Quadriplegia	The Full Amount
Triplegia	Three Quarters The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount
Speech or Hearing	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount
Uniplegia	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount: Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit, to a maximum of $10,000.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit, to a maximum of $5,000.

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments: 4 per lifetime

Maximum Benefit Amount: $24,000

Maximum Benefit Period: 6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

FELONIOUS ASSAULT BENEFIT FOR YOU

Benefit Amount: 50% of the Full Amount of your accidental death and dismemberment insurance benefit, to a maximum of $6,250.

The Felonious Assault Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order to receive the Felonious Assault Benefit, your accidental death and dismemberment must be paid first.

SOME LOSSES MAY NOT BE COVERED UNDER THIS

PLAN. OTHER FEATURES:

Portability

The above items are only highlights of this plan. For a full description of your coverage, please refer to the full certificate of coverage on Premera Blue Cross' web site: www.premera.com/wea**, or you may request a copy by calling Aon Hewitt at (206) 467-4646.**

INDEX

Acupuncture services, 19
Affordable Care Act, 9, 67
Alcohol use, 20
Allowable charge, 67
Ambulance services, 19
Anesthesia services, 41
Anorexia nervosa, 27
Appeals
  Prescription drugs, 35
  See also WEA Claim Review, 9
Biofeedback, 47
Blood products, 19
BlueCard Program, 15
Breast
  Prostheses, 26
  Reconstruction, 26
Bulimia, 27
Case Management, 16
Chemical dependency/ behavioral health, 20
Chemotherapy, 41
  Oral prescription drugs, 33
Childbirth, 31
Children's Health Insurance Program (CHIP), 57
Chiropractic, 41
Claims
  Fraudulent, 49
  Submission, 13
  Timely filing, 13
Clark County, 15
COBRA, 59
Coinsurance, 19
Colonoscopy. *See Preventive Care*, 37
Compounded medications, 33
Contraceptive services, 21
Coordination of benefits, 49
  Dual WEA, 52
  Medicare, 52
Custodial care, 45
Death, subscriber, 56, 59, 62
Deductible, 18
Definitions, 67
Dental services, 22
Dependent
  Change in status, 56
  Dependent verification. *See verifying dependents*, 54
  Eligibility, 54
  Overage, 54, 60
Diagnostic imaging, 22
Dialysis, 22
Disposable medical supplies, 39
Divorce, 56, 59, 62
Doctor visits, 31
Drug abuse, 20
Drug list, preferred, 35
Dual WEA coverage, 52
Eating disorders, 27
Eligibility
  Adoptive children, 55
  Dependent, 54
  Employee, 53
  Legal guardianship, 55
  Marriage, 55
  Medical child support orders, 56
  Newborns, 55
  Surviving dependents, 56
  Verifying dependents, 54
  Working aged, 54
Emergency care, 69
Emergency room, 23
Essential health benefits, 69
Evaluations, mental health, 39
Experimental/investigational, 45, 69
Family medical leave, 58
Fertility drugs, 47
Formulary, 35
Gender Reassignment
  See also Transgender Services, 42
Health management, 23
Home health care, 23
Hospice, 25
Hospital services, 25
Hospital, definition, 69
Individual coverage plans, 62
Individual plan, 62
Infertility treatment, 47
Infusion therapy, 26
Integrated Health Management, 16
Intravenous therapy, 26
Labor dispute, 58
Laboratory services, 22
Layoff, 58
Leave of absence, 57
Limited services, 45
Loss of other coverage, 56
Lymphedema, 26
Mammograms, 22
Massage therapy, 39
Mastectomy, 26
Maternity care, 31
Medical assistance, 57
Medical care, professional, 41
Medical equipment, 37
Medical errors, 48
Medical foods, 27
Medical records, copy, 48
Medically necessary, 70
Medicare
  Coordination of benefits, 52
  Supplement plans, 62
  Working aged, 54
Mental health/behavioral health, 27
Naturopathic medicines, 47
Naturopathic services, 31
Neurodevelopmental care, 29
Never events, 48
Newborn care, 30
Nicotine dependency, 23
  Prescription drugs, 33
Non-covered services, 45
Obstetrical care, 31
Occupational therapy, 39
Office visits, 31
Open enrollment, 57
Oral chemotherapy prescription drugs, 33
Orthotics, 37
Other coverage, 49
Out-of-pocket maximum, 19
Over-the-counter drugs, 33
Oxygen, 39
Personal information, protected, 48
Phenylketonuria (PKU), 27
Physical exams, 36
Physical exams. *See Preventive Care*, 36
Physical therapy, 39
Physician visits, *See Office Visits*, 31
PIP insurance, 53
Plan transfers, 63
Pregnancy, 31
Prescription drugs, 32
  Appeals, 35
  Compounded, 33
  Retail, 32
  Specialty, 33
Preventive care, 31, 36
Preventive screenings, 37
Privacy, 48
Prosthetics, 37
Providers
  Pharmacy, 35
Psychiatric care, 27
Reduction in force, 58
Rehabilitative care, 39
Residential treatment, 27
Retirement, 62
Serious adverse events, 48
Skilled medical care, 40
Skilled nursing facility, 40
Sleep studies, 22
Special enrollment, 57
Speech therapy, 39
Spinal manipulations, 41
Subrogation, 52
Subscriber, death, 56, 59, 62

Substance abuse, 20
Surgical care, professional, 41
Telehealth, 31
Temporomandibular Joint (TMJ)
    Disorders, 32, 42
Testing
    Mental health/Behavioral
        health, 39
    Neuropsychological, 39
    Psychological, 39
TMJ, 46
Transgender Services, 42
Transplants, 43
UIM policy, 52
Urgent care, non-hospital, 31
USERRA, 58
Vision therapy, 44
WEA Claim Review, 9
X-rays, 22

Premera Customer Service (Benefits and Claims)

premera.com/wea

800-932-9221
TTY 800-842-5357

Your Benefits Resources™ (Eligibility and Enrollment)

http://resources.hewitt.com/wea

WEA Select Benefits Center
855-668-5039

WEA Plan Consultant:

Aon Hewitt, an independent provider of plan consultation and administration services, does not provide Premera Blue Cross products or services. Aon Hewitt is solely responsible for their own services.

Life insurance underwritten by:

Unum, an independent provider of life insurance services, does not provide Premera Blue Cross products or services. Unum is solely responsible for its products and services.

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