



MEDICAL PLUS PLAN

U.S. Employees

Group Number: 1000012 & 1000037



Summary Plan Description
Effective Jan 1, 2020



INTRODUCTION TO YOUR HIGH DEDUCTIBLE HEALTH PLAN

This plan meets the requirements of a high deductible health plan for use with a Health Savings Account. Participation in a Health Savings Account is not required for enrollment or continued eligibility on this plan. 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.

This booklet is for members of the Weyerhaeuser Company medical plan. This plan is self-funded by Weyerhaeuser Company, which means that Weyerhaeuser Company is financially responsible for payment of this plan's benefits. Weyerhaeuser Company ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

Weyerhaeuser Company has contracted with Premera Blue Cross an Independent Licensee of the Blue Cross Blue Shield Association to perform administrative duties under the plan, including the processing of claims. Weyerhaeuser Company has delegated to Premera Blue Cross the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent stated in our administrative services contract with the Group. Premera Blue Cross does not insure the benefits of this plan.

In this booklet Premera Blue Cross is called the "Claims Administrator." This booklet replaces any other benefit booklet you may have.

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

Group Name: Weyerhaeuser Company

Effective Date: January 1, 2020

Group Number: 1000012 and 1000037

Plan: Your Future (Non-Grandfathered)

Certificate Form Number: 2020WY01

HOW TO USE THIS BOOKLET

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

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

FOR MORE INFORMATION

Our contact information is on the back cover of this booklet. Please call or write Customer Service for help with:

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

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

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

You can use our Web site to:

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

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ELIGIBILITY

This section of your booklet describes the requirements for you and your dependents to be eligible for coverage.

ELIGIBLE EMPLOYEES

You are eligible for the plan if you are an employee of Weyerhaeuser or a participating subsidiary who is on the U.S. payroll in a position as described below:

- A salaried or hourly production employee with salaried benefits (SHPs) employed full-time or part-time working 25 or more hours per week.
- An eligible hourly production employee who works for Weyerhaeuser on a full-time basis.
- A member of a union that has agreed to offer this plan and who meets the benefits eligibility requirements as defined by the labor contract.

You may also be eligible as a result of a prior coverage continuation election under COBRA, where such election was made under this plan, or under a different plan for which Weyerhaeuser has subsequently designated this plan as replacement or alternative plan.

You are not eligible for the plan if you are performing services for Weyerhaeuser as a contractor, leased employee, or in a temporary capacity (including through a staffing agency), whether or not you are paid by Weyerhaeuser and even if you are later determined to have been a common-law employee for such time period.

ELIGIBLE DEPENDENTS

As an eligible employee, you may elect coverage for your eligible dependents under the plan. Only the dependents who meet the eligibility requirements and rules are eligible for plan coverage. Use this information as a guide to ensure each dependent you enroll in the plan meets plan eligibility requirements and rules.

Spouse

You may elect coverage for your spouse if:

- You elect coverage for yourself.
- Your spouse is legally married to you as defined by federal law, or as allowed in certain states, by common law.

You may not cover a former spouse from whom you are currently divorced or legally separated. Weyerhaeuser-sponsored plans do not recognize (and are not required to recognize) any court-approved divorce decrees that require continued benefit coverage for your former spouse.

Please see note below regarding Dual Coverage if both you and your spouse/domestic partner are eligible employees of Weyerhaeuser.

Domestic Partner

You may elect coverage for your domestic partner if you elect coverage for yourself and you and your domestic partner are both all of the following:

- At least 18 years old and in an exclusive, long-term, committed relationship with each other, and
- Live together (and have done so continuously for at least six months immediately prior to requesting coverage) with the intention to do so indefinitely, and
- Financially interdependent with each other and unrelated by blood, and
- Not legally married to anyone else or a member of another domestic partner relationship, and
- Mentally competent to make a contract.

You must complete the online certification in the enrollment tool to enroll your domestic partner or contact the Employee Service Center at 800-833-0030 to add a domestic partner during the year due to a qualifying status change.

Special rules apply if you want to end coverage during the plan year due to your relationship ending. Call the Employee Service Center at 800-833-0030 for more information.

Please see note below regarding Dual Coverage if both you and your spouse/domestic partner are eligible employees of Weyerhaeuser.

Children

You may elect coverage for your child if:

- You elect coverage for yourself (and your domestic partner, if covering your domestic partner's child).
- The child is under age 26 and is your (or your domestic partner's):
 - Natural or legally adopted child, or
 - Stepchild, or
 - Eligible foster child if placed by an authorized placement agency or by judgment decree, or
 - Child placed in your home for adoption.
 - Child for whom you, your spouse, or your domestic partner have court-appointed guardianship or for whom you have a Qualified Medical Child Support Order (QMCSO).

Note: While you may cover your married or unmarried young adult child, you may not cover his/her spouse or children.

Disabled Children

Your adult child (age 26 and older) may be eligible to remain covered under your plan indefinitely if he or she meets all of the requirements for a child (above) and meets the following additional requirements.

- You elect coverage for yourself (and your domestic partner, if covering your domestic partner's child).
- Your child is already enrolled in the plan on the date he or she otherwise would become ineligible for coverage due to plan age requirements, even if all other criteria are met.

Your adult child must also be disabled, and all of the following must apply. Your child is:

- Deemed disabled by the plan administrator or designee as applicable.
- Unmarried and not covered by another group medical plan as an employee.
- Unable to earn a living because of a continuous physical, developmental, or mental disability that began before age 26.
- Living with you and does not provide more than half of his or her support, or you (or your spouse/domestic partner) provide 50% or more of his or her financial support, regardless of whether the child is living with you.

The child must have been covered and disabled on the day before his/her 26th birthday and you must begin the application process at least 30 days before his/her 26th birthday. If your application for continued coverage is not approved, coverage will end. If approved, ongoing proof of permanent and total disability is required, and failure to respond to ongoing requests for disability information will result in coverage being terminated.

Important

Call the Employee Service Center at 800-833-0030 to request continued coverage at least 31 days before the disabled child's coverage would normally end (e.g. prior to attaining age 26).

Dual Coverage

If both you (the employee) and your spouse/domestic partner are eligible to enroll in this plan as Weyerhaeuser employees, you have two options for coverage:

- You both may enroll as an employee. In this case, each eligible child, if any, can be covered only under your plan or your spouse's/domestic partner's plan (not both), and one spouse/domestic partner cannot be covered as a dependent of the other. Neither you nor your spouse/domestic partner or children may be enrolled twice in this plan.
- One of you may enroll as an employee and the other may be covered (along with any eligible children) as a dependent under that person's coverage.

Certification And Documentation

Any time you elect or maintain coverage for your dependents (spouse/domestic partner, child, or domestic partner's child) you certify that eligible dependents under the plan. You are always responsible for notifying the Employee Service Center as soon as possible, but no later than 31 days, of any changes that may affect the eligibility of your dependent's coverage under the plan.

Periodically you will be required to certify your dependent's plan eligibility; you may also be required to periodically provide documentation that proves your dependent's eligibility. Failure to provide any of the requested certifications or documentation may interrupt or delay coverage under the plan. Weyerhaeuser retains the right to conduct periodic audits of eligible dependents at any time.

Fraudulent Coverage Of Dependents

Weyerhaeuser monitors the eligibility of dependents through periodic audits and investigations. If it is determined that you fraudulently elected or maintained coverage for an ineligible dependent, you may be required to reimburse the cost of any claims or expenses paid under the plan for that dependent. In addition, Weyerhaeuser reserves the right to permanently terminate plan coverage for you and your dependents for fraudulently electing or maintaining coverage for an ineligible dependent. Any employee who fraudulently enrolls or maintains plan coverage for an ineligible dependent may also be subject to disciplinary action, up to and including termination of employment or legal action.

Qualified Medical Child Support Orders

The plan complies with Qualified Medical Child Support Orders (QMCSOs). You may obtain a copy of the plan's QMCSO procedures free of charge by calling the Employee Service Center at 800-833-0030.

ENROLLMENT AND COVERAGE CHANGES

This section describes the steps that are required to enroll in medical coverage or to make changes to your existing level of coverage.

WHEN TO ENROLL

As a newly hired employee, you have 31 days to enroll yourself and dependents in coverage as long as you and your dependents meet the eligibility requirements as covered in the **Eligibility** section.

If you do not enroll in the plan, you will not be covered and will be considered to have waived coverage under the plan. Unless you have a qualifying status change, you must wait until the next open enrollment to enroll in the plan (see the **Changes in Coverage** section).

Please Note: This plan's calendar year deductible and out-of-pocket maximum amounts are higher when a family enrolls than when a subscriber enrolls alone. This means that if a subscriber who had no dependents covered later adds dependents to the plan, the calendar year deductible and out-of-pocket maximum amounts would go up.

However, in any calendar year, no one would have to pay more cost-shares than the individual out-of-pocket maximum shown in the **Summary of your Costs** section.

HOW TO ENROLL

Weyerhaeuser provides benefit enrollment information as part of your onboarding process; you will also receive login information to access the online benefits enrollment tool. You must complete enrollment within 31 days after your first day of work (or your first day of eligibility). For more information, call the Employee Service Center at 800-833-0030.

WHEN COVERAGE BEGINS

As a newly hired employee, after you and your dependents enroll in the plan, medical coverage begins on the first day of the month following your date of hire.

If you enroll for the first time during the annual open enrollment period, coverage will begin on January 1 following the open enrollment period.

WHEN CAN COVERAGE BE CHANGED

You may make changes to your coverage during any annual open enrollment period or within 31 days after a qualifying status change or event as described in the **Changes in Coverage** section.

CHANGES IN COVERAGE

Changes During Open Enrollment

Medical coverage for you and your dependents begins January 1 of the following year if you enroll during open enrollment. Once you enroll in coverage, your election will generally carry forward into the next calendar year unless you make a change to your election during a future open enrollment period or due to a qualifying status change.

If you waive coverage or do not enroll when you first become eligible, or as allowed under the **Changes During the Year** section, you may change your election only during open enrollment.

During open enrollment, you may:

- Enroll yourself, your eligible spouse/domestic partner, eligible children, and your eligible domestic partner's children.

- If you are already enrolled, you may add your eligible spouse/domestic partner, eligible children, and your eligible domestic partner's children.
- Stop coverage for yourself or any covered dependents.

All changes in medical coverage made during open enrollment become effective on January 1 of the following year.

Changes During The Year

If you experience a special enrollment event or qualifying status change, you may:

- Enroll for the first time (if you previously elected to waive coverage).
- Change your existing medical coverage election.

Generally, any election change must be consistent with the qualifying status change that affects eligibility for you, your spouse/domestic partner, your dependent children, or your domestic partner's dependent children under this plan or another employer's plan. Otherwise, you may only make changes during open enrollment. (See **Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Events** and **Qualifying Status Changes** sections for more information.)

Health Insurance Portability And Accountability Act (HIPAA) Special Enrollment Events

During the plan year, at times other than annual open enrollment, you may be eligible for HIPAA special enrollment rights if you experience certain changes in eligibility for benefits under this plan. These rights and the plan allow you to add yourself, if you are not already enrolled and any additional eligible dependents to this plan (even if your other eligible dependents are not directly affected by the event) as long as you enroll within 31 days after the event under the following circumstances:

- You gain a new dependent because of marriage, birth, adoption, or placement for adoption.
- You decline enrollment when initially eligible for yourself, your spouse/domestic partner, and/or your or your domestic partner's dependent children because you (or they) have other medical coverage and eligibility for such coverage is subsequently lost.
 - Coverage loss must be due to loss of eligibility for the other medical coverage other than coverage through Medicare or TRICARE. This includes loss due to divorce, death, termination of domestic partner relationship, termination of employment, or reduction in hours of employment, moving outside of a health maintenance organization plan's service area with no other coverage available from the other employer.
 - If your other medical plan was through COBRA continuation coverage from a previous employer, you must exhaust your COBRA coverage to be eligible for the special enrollment period.
 - If you and/or your dependent becomes eligible to add coverage due to loss of eligibility for Medicaid or a State Children's Health Insurance Program (CHIP); or is determined to be eligible for assistance with the cost of participating in the plan through the Medicaid plan or the State CHIP plan in which you and/or your dependent participate, you may request enrollment in this plan within 60 days of the loss of coverage under Medicaid or CHIP or 60 days from the date you become eligible for the premium subsidy. (See Appendix for additional information about this program).

Important Information about Adding or Dropping Coverage

Making an optional change? If you have a special enrollment event or qualifying status change that allows you to become eligible for coverage during the plan year or allows you to drop coverage for yourself or a dependent, you have 31 days after the date of the special enrollment event or qualifying status change to enroll or end coverage in the plan. Coverage begins on the date of the change if you provide notification within the 31-day period.

Note: If you and/or your dependent are eligible for special enrollment rights through Medicaid or Children's Health Insurance Program (CHIP) and you wish to enroll in this plan, you must enroll in this plan within 60 days of the event.

Dropping an ineligible dependent? You must notify Weyerhaeuser when a dependent loses eligibility for the plan. If your notification is not received within 60 days following the event, your dependent will not be eligible for COBRA continuation of coverage. Coverage ends on the last day of the month following the status change. If eligible, COBRA coverage may be available. Premium refunds are not processed if you fail to notify the Employee Service Center within the prescribed timeframe, and you may be responsible for any claims paid to an ineligible dependent.

Call the Employee Service Center at 800-833-0030 to report these changes.

Qualifying Status Changes

If you experience one of the qualified status changes listed below, you may be able to enroll in plan coverage, change your current plan coverage, or drop your plan coverage during the year. Any change to your plan coverage must be consistent with the status change that affects your or your dependent's eligibility for Company-sponsored plan coverage or coverage sponsored by your eligible dependent's employer. The following qualifying status changes allow you to change your medical coverage mid-year:

- **Legal marital or domestic partnership status.** You marry, divorce, or legally separate; your marriage is annulled; your domestic partner newly meets plan requirements, or your domestic partner relationship ends.
- **Employment status.** Your or your eligible dependent's job situation changes due to termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, a change between a salaried and an hourly position, a change between a part-time and a full-time position, or a change between a salaried non-union position and a union-represented position. If you, your spouse/domestic partner, or dependent child gains eligibility under another employer's plan as a result of a job situation change, your election to stop or change plan coverage will correspond with that status change only if coverage for that individual becomes effective or is increased under the other employer's plan.
- **Leave of absence.** You take an approved unpaid leave of absence.
- **Number of dependents.** You lose a dependent through death, divorce, legal separation, or end of a domestic partnership; you add a dependent through birth, marriage, establishment of a valid domestic partnership, adoption or placement of a child in your home for adoption, or court-appointed guardianship for which you have a legal and financial support obligation.
- **Dependent child's eligibility.** Your or your domestic partner's child becomes eligible or ineligible for coverage (e.g., the child can no longer be covered because he or she turns 26).
- **Judgment, decree, or court order.** You receive a judgment, decree, or court order (e.g., a Qualified Medical Child Support Order) that requires you to add or remove medical coverage for a dependent child.
- **Cost or change in coverage.** If the cost of coverage changes during a plan year by an insignificant amount, your monthly contribution is automatically adjusted. If the cost or level of coverage changes

significantly during a plan year, you may make election changes. The plan administrator determines if a change in cost or level of coverage is significant.

- **Entitlement to Medicare.** You or your dependent becomes eligible for Medicare.
- **Coverage changes due to different enrollment periods under a spouse's/domestic partner's benefit plans.** You may add or stop coverage for yourself, a spouse/domestic partner, or dependent child if the change is due to and corresponds with a change made under a cafeteria plan or qualified benefit plan of your current or former spouse's/domestic partner's or dependent child's employer, and the other plan's coverage period differs from this plan's coverage period. (For example, if your spouse's coverage period is from May 1 to April 30, and he or she drops coverage under that plan, you may enroll your spouse for coverage under the plan.)

WHEN COVERAGE ENDS

Medical coverage will end when any of the following events occur:

- Coverage for yourself:
 - At the end of the month when you are no longer eligible (note – if you qualify for retirement, there is a one-month extension of active coverage for you and your eligible dependents).
 - Your date of death (see **Death** for details on continuation of coverage for family members).
- Coverage for your spouse/domestic partner:
 - The date your coverage ends, unless your coverage ends due to your death (see **Death** for details on continuation of coverage for family members)
 - The last day of the month in which your marriage is annulled or you become legally separated or divorced
 - The last day of the month in which your domestic partner relationship ends
 - The last day of the month in which your spouse/domestic partner becomes ineligible for any other reason
- Coverage for your or your domestic partner's child:
 - The date your coverage ends, unless your coverage ends due to your death (see **Death** for details on continuation of coverage for family members)
 - The last day of the month in which your child becomes ineligible due to the following reasons:
 - Turns age 26
 - Your disabled child over age 25 is no longer disabled or incapacitated or no longer meets the eligibility requirements
 - If your spouse/domestic partner becomes ineligible due to a change in marital or relationship status, your stepchildren or domestic partner's children become ineligible on the last day of the month your spouse/domestic partner became ineligible.

You must promptly notify Weyerhaeuser when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

Weyerhaeuser intends to continue the plan described in this SPD indefinitely. It does, however, reserve the right to amend, modify, suspend, or terminate any benefits in whole or in part, at any time and for any reason. While Weyerhaeuser may terminate the plan at any time, no such termination will affect the right of any employee to receive benefits for claims or services incurred as a plan participant.

WORK AND LIFE EVENTS (CONTINUATION OF COVERAGE)

This section describes how your medical coverage continues when you are no longer actively at work.

LEAVE OF ABSENCE

For specific details and more information about how your leave of absence will affect your other benefits, contact the Employee Service Center at 800-833-0030.

Unpaid Nonmedical Leave

Generally, coverage ends on the last day of the month in which you begin your leave (coverage may be continued through COBRA).

Family And Medical Leave (including FMLA, Disability, or other family and medical leave of absence)

Coverage is extended for all or a portion of your paid disability or approved family or medical leave. Deductions for your contributions continue while you receive pay from Weyerhaeuser (excluding short term disability). After you stop receiving pay, Weyerhaeuser generally continues your coverage for an interim time period. If you are receiving short term disability, the coverage continuation period will not exceed 26 weeks in a 52-week period. After that time, you and/or your covered dependents may continue coverage through COBRA, if you pay the full or a portion of the premium associated with coverage. Continuation and cost is based on the length and type of leave of absence.

If you do not return to work after your approved leave, you and/or your covered dependents may continue coverage through COBRA.

In some cases, Weyerhaeuser may recover premiums it paid for maintaining your medical coverage during your leave if you do not return to work.

Military Leave

Coverage continues during any portion of your paid leave; coverage ends on the last day of the month in which you receive your final pay.

Other Paid Leave

Coverage continues during your paid leave; coverage ends on the last day of the month in which you receive your final pay.

LEAVING THE COMPANY OR RETIREMENT

If you leave the Company before retirement, your plan coverage ends on the last day of the month in which you are employed by the Company. At that time, you may be eligible for COBRA coverage (see **COBRA Coverage** for details).

If you retire from the Company (generally at age 65, or earlier if you meet certain requirements), your plan coverage ends on the last day of the month following the month in which you retire. Upon retirement, you may choose COBRA coverage, if you are eligible to do so. (See **COBRA Coverage** for details).

DEATH

If you die while employed by the Company, plan coverage will continue for your surviving family members through the last day of the month in which you die. Your family will be eligible for up to 3 months of subsidized COBRA coverage (no cost to your family).

If you die while employed by the Company in a work-related accident, plan coverage will continue for your surviving family members through the last day of the month in which you die. Your family will be eligible for up to six months of subsidized COBRA coverage (no cost to your family).

Your surviving family members may be eligible for COBRA coverage, which allows your dependents to continue coverage for a total of 36 months (see **COBRA Coverage** for details).

COBRA COVERAGE (Consolidated Omnibus Budget Reconciliation Act of 1985)

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, which requires continuation of medical coverage to certain eligible employees and/or their covered dependents in most circumstances where coverage would otherwise end. It contains important information about your right to COBRA coverage, which is a temporary extension of coverage under the plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

CONTINUATION OF COVERAGE

COBRA is a term that refers to continuation of your plan coverage when it would otherwise end because of a life event known as a COBRA qualifying event.

After a qualifying event, COBRA coverage must be offered to each person who is a qualified beneficiary. You or your covered spouse/domestic partner, dependent children, or domestic partner's dependent children could become qualified beneficiaries if plan coverage is lost because of a qualifying event. Under the plan, qualified beneficiaries who elect COBRA coverage must pay the full cost of coverage each month (the full premium), plus administration fees. If you or your covered dependents decline this coverage when you first are eligible, you may not enroll at a later date.

You and your covered dependents may continue your current coverage under the plan if coverage ends because of one of these qualifying events:

- You voluntarily terminate employment with Weyerhaeuser.
- Weyerhaeuser ends your employment for any reason unless you are terminated because of gross misconduct.
- The total number of hours you are regularly scheduled to work is reduced below the number required for you to be eligible for benefits.
- You take an unpaid leave of absence.

COBRA coverage also is available for your covered dependents if their coverage would otherwise end because of one of these qualifying events:

- Your death.
- Your divorce, legal separation, or end of your covered domestic partner relationship.
- Your covered child or your domestic partner's covered child becomes ineligible for coverage.

LENGTH OF COBRA COVERAGE

As shown in the following table, COBRA coverage continues for up to 18, 24, 29, or 36 months depending on how you or your covered dependents become eligible. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

Maximum length of COBRA coverage	Reason coverage stops
18 months	<ul style="list-style-type: none"> • Your employment ends for any reason (other than due to gross misconduct) • Your hours of employment are reduced to fewer than the number required to be eligible for the plan • You take an unpaid leave of absence (coverage can continue for the duration of the leave or 18 months, whichever is less); for FMLA leaves, the 18-month COBRA period does not start until the FMLA leave is over
24 months	<ul style="list-style-type: none"> • You take an unpaid military leave as a result of being called to active military duty
29 months	<ul style="list-style-type: none"> • The Social Security Administration determines that you or your covered dependent is permanently disabled. The disability must have started at any point before you have completed the first 60 days of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation of coverage • You or your covered dependent provides notice of the Social Security award within 60 days after the latest of: <ul style="list-style-type: none"> • The date of the determination of disability by the Social Security Administration • The date of the COBRA qualifying event (termination of active coverage) • The date on which the qualified beneficiary loses coverage under the terms of the plan as a result of termination of employment. • You must provide notice of the Social Security Administration's determination of disability prior to the end of the 18-month continuation period. <p>See Disability Determined by Social Security Administration section below.</p>
36 months (for covered dependents)	<ul style="list-style-type: none"> • You die • You and your spouse divorce or legally separate or your relationship with your covered domestic partner ends • Your or your domestic partner's covered child becomes ineligible for coverage

Disability Determined By Social Security Administration

If you or any of your covered dependents are disabled as determined by the Social Security Administration at any point before the end of the first 60 days of the COBRA period, you or your covered dependent must notify Weyerhaeuser's COBRA administrator in writing about the Social Security disability award within 60 days after the latest of:

- The date of the determination of disability by the Social Security Administration
- The date of the COBRA qualifying event (termination of active coverage)
- The date on which the qualified beneficiary loses coverage under the terms of the plan as a result of termination of employment.

You must provide notice of the Social Security Administration's determination of disability prior to the end of the 18-month continuation period. See **Contacting the COBRA Administrator** for contact information.

Military Leave

When the qualifying event is leave of absence from the Company due to an employee being called to active military duty, COBRA coverage lasts for up to 24 months.

Entitlement To Medicare

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for the employee's dependents who are qualified beneficiaries and lost coverage as a result of the qualifying event can last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before his or her employment terminates, COBRA coverage for spouse and children can last up to 36 months after the date of Medicare entitlement, which equals 28 months after the date of the qualifying event (36 months minus eight months).

Note: If the employee becomes eligible for Medicare at any other point in time (either more than 18 months before the qualifying event, or any time after the qualifying event), COBRA coverage for spouse and children will only be available for 18 months.

SECOND QUALIFYING EVENT

If your family experiences another qualifying event while receiving 18 months of COBRA coverage, the covered members of your family may be eligible for up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly and timely given to the COBRA administrator.

This extension may be available to covered dependents if the employee or former employee dies or gets divorced or legally separated, or if the employee's domestic partnership ends, or if the covered child becomes ineligible for coverage under the plan as a **dependent** child, but only if the event would have caused the dependent to lose coverage under the plan had the first qualifying event not occurred.

Important

You must notify the COBRA Administrator within 60 days of the second qualifying event to extend coverage. See **Contacting the COBRA Administrator** for contact information.

ELECTING COBRA COVERAGE

You and your covered dependents will receive election forms and more information about COBRA coverage from Weyerhaeuser's COBRA administrator. In the case of a divorce, a legal separation, or the ineligibility of a dependent child, you or your covered dependents must call the Weyerhaeuser Employee Service Center at 800-833-0030 within 60 days after becoming eligible to elect COBRA coverage. **If you do not notify the Employee Service Center within the 60-day notice period, your family members will lose their right to elect COBRA.**

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your coverage in the plan ends or 60 days after the date you receive the election form and notice of COBRA rights mailed to you by the COBRA administrator, whichever is later. **If you do not submit a completed election form by this due date, you lose your right to elect COBRA coverage.** You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA coverage.

If you elect COBRA coverage because your employment terminated or your hours were reduced, and the Social Security Administration determines that you or a covered dependent is permanently and totally disabled at any time before the end of your initial 60 days of continuation coverage, you or your covered dependent must notify

the COBRA administrator of the determination within the specified timeline (see **Disability Determined by Social Security Administration** section for more information). The notice must be received by the COBRA administrator within the initial 18 months of COBRA coverage so you and your covered dependents can qualify for an additional 11 months of coverage.

WHEN YOU CAN CHANGE COBRA COVERAGE

As a COBRA participant, you have the same opportunity as an active employee to make annual election changes to your benefits through a designated open enrollment period. You may:

- Choose different medical plans if any additional plan choices are available.
- Add or drop covered dependents.
- You can also enroll eligible dependents under special enrollment event and qualified status change rules. (For example, you may add a new dependent acquired through marriage, domestic partnership, birth, or adoption.)
- For more information, see **Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Events** and **Qualifying Status Changes** sections for more information.

Important

Call the Employee Service Center whenever you or your covered dependents experience an event that will end their eligibility to remain enrolled in the plan.

QUALIFIED BENEFICIARIES

To request COBRA coverage, you or your covered dependents are required to notify the Employee Service Center in writing or by phone within a maximum of 60 days after any of the following qualifying events:

- Your divorce or legal separation.
- The end of your domestic partner relationship.
- A dependent child becomes ineligible for coverage.

You will be given at least 60 days from the date coverage ends or the date you receive the COBRA notice and election forms, whichever is later, to elect COBRA coverage.

If you elect COBRA coverage, you or your covered dependents are also required to notify the COBRA administrator in writing within a maximum of 60 days after any of the following:

- A second qualifying event such as a divorce, legal separation, an end of a domestic partner relationship, death, a dependent child ceasing to be a dependent, or Medicare entitlement.
- Social Security Administration determination of disability.
- Social Security Administration determination of cessation of disability.

The notification must include your name, address, relationship to the employee, and a description and date of the qualifying event. See **Contacting the COBRA Administrator** for contact information.

Children Born To Or Placed For Adoption During The Cobra Period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, the covered employee has elected coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as the COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs

A covered employee's child receiving plan benefits under a Qualified Medical Child Support Order (QMCSO) that Weyerhaeuser receives during the covered employee's period of employment with Weyerhaeuser is entitled to the same COBRA coverage rights as an eligible dependent child of the covered employee.

WHEN COBRA COVERAGE ENDS

COBRA coverage ends when the earliest of the following events occurs:

- The maximum COBRA period (18, 24, 29, or 36 months) ends.
- Premiums are not paid on a timely basis.
- Weyerhaeuser terminates the plan or amends the plan to eliminate coverage and does not provide any other group dental plans to employees.
- The person who elected COBRA coverage becomes covered under another group dental plan after he or she has elected to continue coverage through COBRA and meets any pre-existing condition prohibitions or limitations affecting him or her.

TRADE ACT OF 2002

The Trade Act of 2002 provides health care coverage expansion to certain employees who have lost their jobs or had a reduction in hours as a direct result of competition from foreign trade or production being moved overseas. As a result of this act, affected employees may be eligible for a second 60-day COBRA election period if they did not elect COBRA coverage when first eligible. This second election period begins on the first day of the month in which the employee is determined to be eligible for trade adjustment assistance (TAA).

In addition, TAA-eligible employees may also qualify for a federal tax credit of 65% of the COBRA premium if they elect COBRA coverage. If you are eligible for this tax credit, there are two options available to you for receiving this credit:

- Elect to claim the 65% credit on your annual federal tax return.
- Obtain an advance credit of 65% and pay the 35% balance of the monthly premium.

You will be notified if you are determined TAA-eligible. If you have questions about the Trade Act of 2002 or your eligibility for TAA assistance, contact SHPS, Weyerhaeuser's COBRA administrator. See **Contacting the COBRA Administrator** for contact information for Conexis.

COBRA GENERAL NOTICE

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) is a federal law requiring employers to offer continued benefits coverage to employees and/or their covered dependents in circumstances in which coverage would generally otherwise end. When a participant continues coverage through COBRA, he or she is responsible for paying the full cost of coverage each month (the full premium), plus a 2% administration fee.

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 Weyerhaeuser and Premera is terminated.

CONTINUATION UNDER USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights to employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have

the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

CONTACTING THE COBRA ADMINISTRATOR

To reach the COBRA plan administrator, contact:

WageWorks

1-877-722-2667

mybenefits.wageworks.com

SUMMARY OF YOUR COSTS

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

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

- The **networks**. To help control the cost of your care, this plan uses Premera’s Heritage network in Washington. You may be able to save money if you use an in-network provider. For more network details, see ***How Providers Affect Your Costs***.

If you need certain spinal surgeries or cellular immunotherapy and gene therapy, you may be able to save money by using Select Blue Distinction Centers Plus. See ***Select Blue Distinction Centers Plus*** in the summary table and in ***Covered Services***.

- The **allowed amount**. This is the most this plan allows for a covered service. It is often lower than the provider's billed charge. Providers not in one of the plan's networks have the right to bill you for amounts over the allowed amount. See ***Important Plan Information*** for details. For some covered services, you have to pay part of the allowed amount. This is called your **cost-share**. This plan's cost-shares are explained below. You will find the amounts in the summary table.
- The **deductible**. The total allowed amount you pay in each year before this plan starts to make payments for your covered healthcare costs. You pay down the deductible with each claim. The deductible amount depends on whether a subscriber enrolls with or without a spouse and/or children. See ***Important Plan Information*** for more details.

	In-Network Providers	Out-of-Network Providers
Subscriber-only deductible	\$1,400	Shared with in-network
Subscriber+1 dependent deductible	\$2,800	Shared with in-network
Subscriber+2 or more dependents	\$3,500	Shared with in-network

- **Coinsurance**. For some healthcare, you pay a percentage of the allowed amount, and the plan pays the rest. This booklet calls your percentage “coinsurance.” You pay less coinsurance for many benefits when you use an in-network provider. Your coinsurance is shown in the summary table.
- The **out-of-pocket maximum** (not shown in the summary table). This is the most you pay each calendar year for any deductibles, copays and coinsurance. Not all the amounts you have to pay count toward the out-of-pocket maximum. No enrolled family member has to pay more than the individual out-of-pocket maximum. See ***Important Plan Information*** for details.

	In-Network Providers	Out-of-Network Providers
Subscriber-only out-of-pocket maximum	\$3,425	None
Subscriber+1 dependent out-of-pocket maximum	\$6,850	None
Subscriber+2 or more dependents out-of-pocket maximum (no one family member need pay more than \$6,850 of this maximum)	\$7,500	None

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

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

SUMMARY TABLE

The summary table below shows plan limits and what you pay (your cost-shares) for covered services.

Facility in the table below means hospitals or other medical institutions. **Professional** means doctors, nurses, and other people who give you your care. **No charge** means that you do not pay any deductible, copay or coinsurance for covered services. **No cost-shares** means that although you do not pay any deductible, copay or coinsurance for covered services, the provider can bill you for amounts over the allowed amount. **The table also shows the subscriber-only deductible. The subscriber+dependent deductible is two times the deductible amount shown.** The deductible that applies to you depends on whether the subscriber is covering dependents or not.

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture calendar year limit: 12 visits	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Allergy Testing and Treatment	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Ambulance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Assisted Reproduction Lifetime maximum: \$5,000 For coverage of prescription drugs, see the Prescription Drug benefit.		
• Office and clinic visits	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Inpatient facility care	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Surgery and inpatient professional care	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Outpatient surgery center	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Surgery and other professional services	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Testing	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Blood Products and Services	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Cellular Immunotherapy And Gene Therapy	Covered as any other in-network service	Covered as any other out-of-network service
Chemotherapy and Radiation Therapy Professional and facility services	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Clinical Trials Covers routine patient care during the trial	Covered as any other service	Covered as any other service
Dental Care		
• Dental Anesthesia (up to age 19 when medically necessary)		
• Inpatient facility care	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Outpatient surgery center	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Anesthesiologist	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• Dental Injury	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Diagnostic X-Ray, Lab And Imaging for medical conditions or symptoms Tests, lab, imaging and scans	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Dialysis For permanent kidney failure. See the Dialysis benefit for details.		
• During Medicare's waiting period	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
• After Medicare's waiting period	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Emergency Room</p> <ul style="list-style-type: none"> • Facility charges. You may have additional costs for other services. Examples are X-rays or lab tests. See those covered services for details. • Professional services 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>
<p>Foot Care such as trimming nails or corns, when medically necessary due to a medical condition</p>	<p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p>
<p>Home Health Care calendar year limit: 130 visits</p> <ul style="list-style-type: none"> • Home visits • Prescription drugs billed by the home health agency 	<p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p>
<p>Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies</p> <ul style="list-style-type: none"> • Medical vision hardware • Sales tax for covered items • Foot orthotics and therapeutic shoes; calendar year limit: None • Medical vision hardware for members 19 or older (see the Vision Hardware benefit for members under 19) 	<p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p>
<p>Hospice Care Lifetime limit for terminal illness: 6 months Lifetime limit for non-terminal illness: none Inpatient stay limit: 30 days Home visits: Unlimited Respite care: 240 hours</p> <ul style="list-style-type: none"> • Inpatient facility care • Home and respite care • Prescription drugs billed by the hospice 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Hospital <ul style="list-style-type: none"> • Inpatient Care <ul style="list-style-type: none"> • Professional • Facility • Outpatient Care <ul style="list-style-type: none"> • Professional • Facility 	Deductible, then 15% coinsurance Deductible, then 15% coinsurance Deductible, then 15% coinsurance Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Deductible, then 35% coinsurance Deductible, then 35% coinsurance Deductible, then 35% coinsurance Deductible, then 35% coinsurance Deductible, then 35% coinsurance
Infusion Therapy	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Massage Services of a massage practitioner calendar year visit limit: 75 visits combined with outpatient neurodevelopmental and rehabilitation therapy visit limits.	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Mastectomy and Breast Reconstruction <ul style="list-style-type: none"> • Office and clinic visits, and other professional services • Inpatient facility care 	Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Deductible, then 35% coinsurance Deductible, then 35% coinsurance
Maternity Care Care during pregnancy, childbirth and after the baby is born. See the Preventive Care benefit for routine exams and tests during pregnancy. Abortion is also covered. <ul style="list-style-type: none"> • Professional care • Inpatient hospital, birthing centers and short-stay hospitals 	Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Deductible, then 35% coinsurance Deductible, then 35% coinsurance
Medical Foods includes phenylketonuria (PKU)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Medical Transportation Travel and lodging are covered up to the IRS limitations. Must be arranged by Premera. Prior Authorization required. For transplants: limit per transplant: \$7,500 For surgeries covered under the <i>Premera-Designated Centers of Excellence</i> benefit: To/from Premera-Designated Center of Excellence To other providers For cellular immunotherapy and gene therapy: \$7,500 per episode of care To/from designated provider To/from other providers Special criteria are required for travel benefits to be provided. Please see the benefit for coverage details.</p>	<p>Deductible, then 0% coinsurance</p> <p>Deductible, then 0% coinsurance</p> <p>Not covered</p> <p>Deductible, then 0% coinsurance</p> <p>Not covered</p>	<p>Deductible, then 0% coinsurance</p> <p>n/a</p> <p>Not covered</p> <p>n/a</p> <p>Not covered</p>
<p>Mental Health Care</p> <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient and residential facility care Outpatient facility care 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>
<p>Neurodevelopmental Therapy (Habilitation) See the <i>Mental Health Care</i> benefit for therapies for mental conditions such as autism.</p> <ul style="list-style-type: none"> Outpatient care calendar year visit limit: 75 visits combined with outpatient rehabilitation therapy and massage therapy visit limits. Inpatient care calendar year day limit: 30 days 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>
<p>Newborn Care</p> <ul style="list-style-type: none"> Inpatient care Outpatient care 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Orthognathic Surgery (Jaw Augmentation or Reduction) <ul style="list-style-type: none"> • Surgery and professional care • Outpatient surgery facility care 	Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Deductible, then 35% coinsurance Deductible, then 35% coinsurance
Premera-Designated Centers Of Excellence Program This benefit covers the services listed below. Special criteria are required for coverage. Please see the benefit for coverage details. For surgeries by providers other than Premera-designated centers of excellence, please see the Surgery benefit. Covered services are: <ul style="list-style-type: none"> • Total knee and hip joint replacement • Spinal surgery • Cardiac surgery • Bariatric surgery 	No charge No charge No charge No charge	n/a n/a n/a n/a
Prescription Drug In no case will you pay more than the cost of the drug or supply. Covered Drugs <ul style="list-style-type: none"> • Preferred Generic drugs • Preferred brand name drugs • Non-preferred generic and brand name drugs <ul style="list-style-type: none"> • Preferred Generic drugs • Preferred brand name drugs • Non-preferred generic and brand name drugs Specialty Drugs Specialty drugs <ul style="list-style-type: none"> • Preferred specialty drugs • Non-preferred specialty drugs 	In-Network Retail Pharmacy Deductible, then 15% coinsurance Deductible, then 15% coinsurance Deductible, then 30% coinsurance In-Network Mail-Order Pharmacy Deductible, then 15% coinsurance Deductible, then 15% coinsurance Deductible, then 30% coinsurance In-Network Specialty Pharmacy Deductible, then 15% coinsurance 30% allowed amount	Out-Of-Network Retail Pharmacy Not covered Not covered Not covered Out-Of-Network Mail-Order Pharmacy Not covered Not covered Not covered Out-Of-Network Specialty Pharmacy Not covered Not covered

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Infertility Drugs, including fertility enhancement medications are limited to a lifetime benefit of \$1,000 per member.</p> <p>Erectile Dysfunction/Impotence Impotency drugs (except for Cialis) 2.5mg and 5mg are limited as follows:</p> <ul style="list-style-type: none"> • Retail pharmacy is limited to 8 tablets or injections per a 30 day period. • Mail-order pharmacy is limited to 24 tablets or units in a 90 day period. <p>PV1 Preventive Drugs Generic and brand-name drugs</p>	<p>In-Network Retail or In-Network Mail Order Pharmacy</p> <p>Deductible, then 15% coinsurance</p>	<p>Out-Of-Network Retail Pharmacy</p> <p>Not covered</p>
	<p>Deductible, then 15% coinsurance</p>	<p>Not covered</p>
	<p>No charge</p>	<p>Not covered</p>
<p>Exceptions</p> <ul style="list-style-type: none"> • Certain prescription drugs and generic over-the-counter drugs to break a nicotine habit • Drugs on the Affordable Care Act's preventive drug list • Female birth control drugs, devices and supplies (prescription and over-the-counter). Includes emergency birth control. 	<p>In-Network Retail or In-Network Mail Order Pharmacy</p> <p>No charge</p>	<p>Out-Of-Network Retail Pharmacy</p> <p>Not covered</p>
	<p>No charge</p>	<p>Not covered</p>
	<p>No charge</p>	<p>Not covered</p>
<p>Preventive Care (Limits on how often services are covered and who services are recommended for may apply.)</p> <ul style="list-style-type: none"> • Preventive exams, including vision and oral health screening for members under 19, diabetes and depression screening • Immunizations in the doctor's office 	<p>In-Network Providers</p> <p>No charge</p> <p>No charge</p>	<p>Out-of-Network Providers</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<ul style="list-style-type: none"> Flu shots and other seasonal immunizations at a pharmacy or mass immunizer location Travel immunizations at a travel clinic or county health department Diabetes health education Health education and training (outpatient) Nicotine habit-breaking programs Fall prevention for members 65 and older Nutritional counseling and therapy Screening tests (includes mammograms, prostate and cervical cancer screening) Colon cancer screening <i>Clinical age and frequency limitations apply to colon cancer screening. See the Preventive Care benefit.</i> Low dose CT scans of the thorax for those at risk of lung cancer due to age or smoker status. Limit: 1 per calendar year Pregnant women's care (includes breast-feeding support and post-partum depression screening) Female birth control and sterilization See the Surgery benefit for coverage of male sterilization. 	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Deductible, then 35% coinsurance</p> <p>No cost-shares</p> <p>No cost-shares</p> <p>No cost-shares</p> <p>No cost-shares</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>
<p>Professional Visits and Services</p> <ul style="list-style-type: none"> Office and clinic visits, including telemedicine Other professional services 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>
<p>Psychological and Neuropsychological Testing calendar year visit limit: 12 hour testing limit (mental health/autism related visits are unlimited)</p>	<p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Rehabilitation Therapy</p> <ul style="list-style-type: none"> Outpatient Visits calendar year visit limit: 75 visits combined with outpatient rehabilitation therapy and massage therapy visit limits There is no limit for cardiac or pulmonary rehabilitation programs, or similar programs for cancer or other chronic conditions. Office and clinic visits Other outpatient services Inpatient Care calendar year day limit: 30 days 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>
<p>Select Blue Distinction Centers Plus</p> <p>For certain spinal surgeries, cellular Immunotherapy and gene therapy procedures. See benefit for details.</p> <ul style="list-style-type: none"> Select Blue Distinction Centers Plus Travel to the Select Center, if needed, up to \$3,000 per surgery or infusion Other Blue Distinction Centers Plus (Travel not covered) Other providers (Travel not covered) 	<p>Deductible, then 0% coinsurance</p> <p>Deductible, then 0% coinsurance</p> <p>Deductible, then 15% coinsurance</p> <p>Deductible, then 35% coinsurance</p>	<p>Not applicable</p> <p>Not applicable</p> <p>Not applicable</p> <p>Deductible, then 35% coinsurance</p>
<p>Skilled Nursing Facility Care calendar year day limit: 90 days</p>	<p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p>
<p>Spinal and Other Manipulations calendar year visit limit: 24 visits</p>	<p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p>
<p>Substance Use Disorder</p> <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient and residential facility care Outpatient facility care 	<p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p> <p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p> <p>Deductible, then 35% coinsurance</p>
<p>Surgery (includes anesthesia and blood transfusions) See the Hospital and Surgical Center Care – Outpatient benefits for facility charges.</p>	<p>Deductible, then 15% coinsurance</p>	<p>Deductible, then 35% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Surgical Center Care – Outpatient	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Temporomandibular Joint Disorders (TMJ) Care <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient facility care 	Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Deductible, then 35% coinsurance Deductible, then 35% coinsurance
Therapeutic Injections	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Transgender Services <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient facility care 	Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Deductible, then 35% coinsurance Deductible, then 35% coinsurance
Transplants (Includes donor search and donation costs) <ul style="list-style-type: none"> Inpatient facility care Office and clinic visits Surgery and other professional services <i>*All approved transplant centers covered at the in-network level</i>	Deductible, then 15% coinsurance Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Not covered* Not covered* Not covered*
Urgent Care Services at an urgent care center. (See Diagnostic X-Ray, Lab And Imaging for tests received while at the center.) <ul style="list-style-type: none"> Freestanding urgent care centers Urgent care centers attached to or part of a hospital 	Deductible, then 15% coinsurance Deductible, then 15% coinsurance	Deductible, then 35% coinsurance Deductible, then 35% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Vision Hardware <ul style="list-style-type: none"> Members 19 And Older Limit every 2 consecutive calendar years: \$200 For Members Under 19 <ul style="list-style-type: none"> Glasses (frames and lenses), lens features covered are polycarbonate lenses and scratch resistant coating) Limit every 2 consecutive calendar years: 1 pair of frames. Calendar year limit: 1 pair of lenses OR 1 year supply of contact lenses. Contact lenses and glasses required for medical reasons such as aphakia or keratoconus Low vision devices, high power glasses, magnifiers and telescopes when medically necessary 	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>No cost-shares</p> <p>No cost-shares</p> <p>No cost-shares</p> <p>No cost-shares</p>

HOW PROVIDERS AFFECT YOUR COSTS

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

IN-NETWORK PROVIDERS

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

In-Network providers are:

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

In-Network pharmacies are available nationwide.

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

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

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

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

CONTINUITY OF CARE

If you are in active relationship and treatment, and your doctor or health care provider is no longer in your network, you may be able to continue to see that provider for a period of time. An "active relationship" means that you have had three or more visits with the provider within the past 12 months.

Continuity of care does not apply if your provider:

- No longer holds an active license

- Relocates out of the service area
- Goes on leave of absence
- Is unable to provide continuity of care because of other reasons
- Does not meet standards of quality of care

You must continue to be enrolled on this plan to be eligible for any continuity of care benefit.

We will notify you immediately if the provider contract termination will happen within 30 days. Otherwise, we will notify you no later than 10 days after the provider's contract ends if we know that you are under an active treatment plan. If we learn that you are under an active treatment plan after your provider's contract ends, we will notify you no later than the 10th day after we become aware of this fact.

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

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

- The 90th day after we notified you that your provider's contract ended
- The 90th day after we notified you that your provider's contract ended, or the date your request for continuity of care was received or approved, whichever is earlier
- The day after you complete the active course of treatment entitling you to continuity of care
- If you are pregnant, and become eligible for continuity of care after commencement of the second trimester of the pregnancy, you will receive continuity of care
- As long as you continue under an active course of treatment, but no later than the 90th day after we notified you that your provider's contract ended, or the date your request for continuity of care was received or approved, whichever is earlier

When continuity of care ends, you may continue to receive services from this same provider, however, the plan will pay benefits at the out-of-network benefit level. Please see the **Summary Of Your Costs** for more information. If we deny your request for continuity of care, you may appeal the denial. Please see **Complaints and Appeals**.

OUT-OF-NETWORK PROVIDERS

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

- Some providers in Washington that are not in the Heritage network do have a contract with us. Even though your bills will be reimbursed at the lower percentage (the out-of-network benefit level), these providers will not bill you for any amount above the allowed amount for a covered service. The same is true for a provider that is in a different network of the local Host Blue.
- There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers are called "non-contracted" providers in this booklet. Their covered services are based on a lower allowed amount. See **Important Plan Information**. "Non-contracted" providers have the right to charge you more than the allowed amount for a covered service. You may also be required to submit the claim yourself. See **How Do I File A Claim** for details.

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

Services you receive in an in-network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are out-of-network providers. When you receive services from these out-of-network

providers, you may be responsible for amounts over the allowed amount as explained above.

IN-NETWORK BENEFITS FOR OUT-OF-NETWORK PROVIDERS

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

- Emergency care for a medical emergency. (Please see the **Definitions** section for definitions of these terms.) This plan provides worldwide coverage for emergency care.
The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is an in-network provider. Emergency care furnished by an out-of-network provider will be reimbursed at the in-network benefit level. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowed amount.
- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Heritage provider who doesn't have admitting privileges at a Heritage hospital.
- Covered services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-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.

IMPORTANT PLAN INFORMATION

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

The allowed amount is also explained.

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

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the allowed amount (please see the **Allowed Amount** subsection below in this booklet).

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

Your calendar year deductible is dependent upon whether you're enrolled as an individual (subscriber only) or as part of a family (subscriber plus one or more dependents).

Subscriber-Only Deductible

When a subscriber enrolls without dependents, the subscriber must pay a fixed amount called the subscriber-only deductible before certain benefits of this plan are provided. The subscriber-only deductible does not apply to a subscriber when he or she enrolls with other family members.

Subscriber+Dependent Deductible

When a subscriber enrolls with dependents, they have a different calendar year deductible, called the subscriber+dependent deductible. This is the amount that the entire family (subscriber plus one or more enrolled dependents) must pay in total each calendar year before benefits are provided. The subscriber+dependent deductible is an "aggregate" amount, meaning that it can be met by one family member or all family members in combination. Benefits are not provided for any family member until the total subscriber+dependent deductible has been reached. This is true even if the subscriber has paid an amount equal to the subscriber-only deductible.

Please Note: If a subscriber adds or drops dependents from coverage during the calendar year, the calendar year deductible will change to the subscriber-only or subscriber+dependent calendar year deductible when appropriate. If the subscriber adds dependents, any amounts applied to the subscriber-only deductible would be credited toward the subscriber+dependent deductible.

What Doesn't Apply To The Calendar Year Deductible?

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

- Amounts that exceed the allowed amount
- Charges for excluded services

COINSURANCE

"Coinsurance" is a defined percentage of allowed amounts for covered services and supplies you receive. It's the percentage you're responsible for, not including the calendar year deductible and any copays, when the plan provides benefits at less than 100% of the allowed amount.

OUT-OF-POCKET MAXIMUM

Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay coinsurance and copays, if any, until your individual out-of-pocket maximum is reached. The out-of-pocket maximum is the maximum amount each member could pay each calendar year for covered services and supplies furnished by in-network providers. There is no out-of-pocket maximum limit for services of out-of-network providers. This plan has 2 out-of-pocket maximums. One is for subscribers enrolling without dependents, called the individual out-of-pocket maximum. The other is for subscribers enrolling with dependents. That one is called the family out-of-pocket maximum.

The family out-of-pocket maximum works differently than the plan's subscriber+dependent deductible. Unlike the deductible, the annual out-of-pocket maximum for any one member cannot be more than the individual out-of-pocket maximum limit set by federal law. To comply, when any one member's cost-shares equal the individual out-of-pocket maximum, the plan's family maximum for the calendar year will be met for that member. The balance of the family out-of-pocket maximum must then be reached by one or more of the remaining members in order for the family maximum for the calendar year to be met for all those members.

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

Expenses that apply to the out-of-pocket maximum are:

- The calendar year deductible
- Coinsurance

Expenses that do not apply to the out-of-pocket maximum are:

- Charges above the allowed amount
- Charges not covered by the plan
- Your cost-shares for services of out-of-network providers. However, benefits that always apply in-network cost-shares, like the Emergency Room Services benefit, will apply toward the out-of-pocket maximum.

ALLOWED AMOUNT

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us. The allowed amount is described below. There are different rules for dialysis due to end-stage renal disease and for emergency services. These rules are shown below the general rules.

General Rules

• Providers In Washington and Alaska Who Have Agreements With Us

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

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

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

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

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

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

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

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

Dialysis Due To End Stage Renal Disease

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

The allowed amount is the amount explained above in this definition.

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

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

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

See the Dialysis benefit for more details.

Emergency Care

Consistent with the requirements of the Affordable Care Act, the allowed amount 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 out-of-network providers

In addition to your deductible, copays and coinsurance, you will be responsible for charges received from out-of-network providers above the allowed amount.

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 allowed amount, and for your normal share of the allowed amount (see the ***Summary Of Your Costs*** for further detail).

Note: Non-contracted ambulances are always paid based on billed charges.

The allowed amount will be the amount allowed for out-of-network providers even when the provider's services are covered at the in-network benefit level.

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

COVERED SERVICES

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be medically necessary (please see the **Definitions** section in this booklet) and must be furnished in a medically necessary setting.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan.
- It must be furnished by a "provider" (please see the **Definitions** section in this booklet) who's performing services within the scope of his or her license or certification.
- It must meet the standards set in our medical and payment policies. The plan uses policies to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at www.premera.com or by calling Customer Service.

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

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

ACUPUNCTURE

This benefit covers acupuncture to:

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

ALLERGY TESTING AND TREATMENT

This benefit covers:

- Testing
- Allergy shots
- Serums

AMBULANCE

This benefit covers:

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

These services are only covered when:

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

Air or sea emergency medical transportation is covered when:

- The above requirements for ambulance services are met, and
- Geographic restraints prevent ground emergency transportation to the nearest facility that can treat your condition, or ground emergency transportation would put your health or safety at risk

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

ASSISTED REPRODUCTION

This benefit covers assisted reproduction methods. An example is in-vitro fertilization. Also covered are procedures to undo sterilization surgery. Related imaging and lab tests are also covered. These services are not covered under other benefits of this plan.

Take-home drugs to treat infertility or that are required for assisted reproduction procedures are covered under the **Prescription Drug** benefit. However, these drugs are subject to the maximum for this benefit shown in the **Summary Of Your Costs**.

This benefit doesn't cover:

- Testing to determine if a member is infertile. Such tests are covered under the **Diagnostic Lab, X-Ray And Imaging** benefit.
- Medical services to diagnose and correct medical conditions that may cause infertility, including tests to monitor the outcomes. Please see the **Diagnostic Lab, X-Ray And Imaging** and **Surgery** benefits.

BLOOD PRODUCTS AND SERVICES

Benefits are provided for blood and blood derivatives.

CHEMOTHERAPY AND RADIATION THERAPY

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs
- Extractions to prepare the jaw for radiation treatment

For drugs you get from a pharmacy, see **Prescription Drug**. Some services need prior authorization before you get them. See **Prior Authorization** for details.

CELLULAR IMMUNOTHERAPY AND GENE THERAPY

Benefits are provided for medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy. The plan will cover designated providers outside the service area when there are no in-network providers within the service area.

Services must meet Premera's medical policy. You can access our medical policies by contacting Customer Service or going to **premera.com**. Services also require prior authorization. See **Prior Authorization**.

CLINICAL TRIALS

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

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

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

This benefit doesn't cover:

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

DENTAL CARE

Dental Anesthesia

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

This benefit covers:

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

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

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

Dental Injury

Treatment of dental injuries to teeth, gum and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment
- Oral surgery

This benefit is covered on sound and natural teeth that:

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

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

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

DIAGNOSTIC X-RAY, LAB AND IMAGING

Covered services include:

- Bone density screening for osteoporosis
- Cardiac testing
- Pulmonary function testing
- Diagnostic imaging and scans such as x-rays
- Lab services
- Mammograms (including 3-D mammograms) for a medical condition
- Neurological and neuromuscular tests
- Pathology tests
- Echocardiograms
- Ultrasounds
- Computed Tomography (CT) scan
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan

For additional details see the following benefits:

- **Preventive Care**
- **Hospital**
- **Emergency Room**

Some tests need to be approved before you receive them. See **Prior Authorization** for details.

DIALYSIS

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

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

If you have a health savings account, you should ask a tax advisor how having Medicare affects your ability to put money into that account.

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

If the dialysis services are provided by a non-contracted provider and you do not enroll in Medicare, then you will owe the difference between the non-contracted provider's billed charges and the plan's payment for the covered services.

EMERGENCY ROOM

This benefit covers:

- Emergency room and doctor services
- Equipment, supplies and drugs used in the emergency room
- Services and exams used for stabilizing an emergency medical condition
- Diagnostic tests performed with other emergency services
- Medically necessary detoxification

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

You may need to pay charges over the allowed amount if you get care from a provider not in your network. See **How Providers Affect Your Costs** for details.

FOOT CARE

This benefit covers the following medically necessary foot care services that need care from a doctor:

- Foot care for members with impaired blood flow to the legs and feet when it puts the member at risk
- Treatment of corns, calluses and toenails

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

HOME HEALTH CARE

Care is covered when a doctor states in writing that care is needed in your home. The care needs to be done by staff who works for a home health agency that is state-licensed or Medicare-certified.

Home health care provided as an alternative to hospitalization must have a written plan of care from your doctor. This type of care is not subject to any visit limit shown in the **Summary of Your Costs**. Medically intensive care in the home, or skilled hourly care provided as an alternative to facility-based care must have prior authorization to be covered.

This benefit covers:

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

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

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

This benefit does not cover:

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

HOME MEDICAL EQUIPMENT (HME), ORTHOTICS, PROSTHETICS AND SUPPLIES

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

Covered items include:

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

Medical Supplies such as:

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

Medical Vision Hardware for members age 19 and older to correct vision due to medical eye conditions such as:

- Corneal ulcer
- Bullous keratopathy
- Recurrent erosion of cornea
- Tear film insufficiency
- Aphakia
- Sjogren's disease
- Congenital cataract
- Corneal abrasion
- Keratoconus
- Progressive high (degenerative) myopia
- Irregular astigmatism
- Aniridia

Medical vision hardware for members under age 19 is covered under ***Vision Hardware***.

External Prosthetics and Orthotic Devices used to:

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

Orthopedic Shoes and Shoe Inserts

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

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

Items prescribed for the treatment of diabetes are not subject to the yearly limit shown in the **Summary Of Your Costs**.

This benefit does not cover:

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

HOSPICE CARE

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

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

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

The Hospice Care benefit covers:

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

Covered services are:

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

This benefit doesn't cover:

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

HOSPITAL

This benefit covers:

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

Even though you stay at an in-network hospital, you may get care from doctors or other providers who do not have a network contract at all. In that case, you will have to pay any amounts over the allowed amount.

You pay out-of-network cost shares if you get care from a provider not in your network. See **How Providers Affect Your Costs** for details.

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

This benefit does not cover:

- Hospital stays that are only for testing, unless the tests cannot be done without inpatient hospital facilities, or your condition makes inpatient care medically necessary

- Any days of inpatient care beyond what is medically necessary to treat the condition

INFUSION THERAPY

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

Infusion examples include:

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

This benefit covers:

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

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

MASSAGE

Benefits are provided as shown in the **Summary Of Your Costs** for massage therapy to treat a covered illness, injury or condition. Services must be provided by a massage therapist who is licensed or certified as required by the state in which services are provided. The services must be within the scope of the massage therapist license or certification.

Massage therapist are not covered under any other benefits of this plan.

See the **Rehabilitation Therapy** benefit for coverage of physical and other rehabilitative therapies. Massage therapy by other providers is not covered under this benefit.

MASTECTOMY AND BREAST RECONSTRUCTION

Mastectomy and breast reconstruction services are covered on the same basis as any other condition.

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

This benefit covers:

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

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

MATERNITY CARE

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

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

Facility Care

This benefit covers inpatient hospital, birthing center, outpatient hospital and emergency room services,

including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

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

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

Professional Care

This benefit covers:

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

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

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

MEDICAL FOODS

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

This benefit covers:

- Dietary replacement to treat inborn errors of metabolism (example phenylketonuria (PKU))
- Dietary replacement when you have a severe allergy to most foods based on white blood cells in the stomach and intestine that cause inflammation (eosinophilic gastrointestinal associated disorder)
- Other severe conditions when your body cannot take in nutrient from food in the small intestine (malabsorption) disorder
- Disorders where you cannot swallow due to a blockage or a muscular problem and need to be fed through a tube

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

This benefit does not cover:

- Oral nutrition or supplements not used to treat inborn errors of metabolism or any of the above listed conditions

- Specialized infant formulas
- Lactose-free foods

MEDICAL TRANSPORTATION

This plan provides benefits for travel and lodging only for certain covered services as described below. The member must live more than 50 miles away from the provider performing the services, unless transplant protocols require otherwise. Please contact Customer Service to access our travel partner. **Air transportation and lodging must be booked by Premera's travel partner in order to be covered.** Prior authorization is also required.

- Travel related to the covered transplants named in the **Transplants** benefit. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members not in the hospital and for their companions. The member getting the transplant must live more than 50 miles from the transplant facility unless treatment protocols require the member to remain closer to the transplant center.
- Travel and lodging expenses related to services provided by Designated Centers of Excellence. Please see **Premere-Designated Centers Of Excellence Program** for medical care covered by this benefit.
- Travel for immunotherapy and gene therapy. Benefits are provided for travel for the member and one companion to a designated provider outside the service area, when a designated provider is not available within the service area. Please see **Cellular Immunotherapy And Gene Therapy**.

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

Benefits are provided for:

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

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

Companion Travel

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

Reimbursement of Travel Claims

There are some covered travel services that are not arranged by Premera's travel partner. For these services, you must submit a Travel Claim Form. A separate claim form is needed for each patient and each commercial carrier or transportation service used. You can get Travel Claim Forms on our website at **premera.com**. You can also call us for a copy of the form.

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

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

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

This benefit does not cover:

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

MENTAL HEALTH CARE

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

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

Covered mental health services are:

- Inpatient care
- Outpatient therapeutic visits. "Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Current Procedural Terminology** manual, published by the American Medical Association. Outpatient therapeutic visits can include real-time visits with your doctor or other provider via telephone, online chat or text, or other electronic methods (telemedicine).
- Treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
- Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders.
- Applied behavioral analysis (ABA) therapy for members with one of the following:

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

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

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

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

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

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

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

For chemical dependency treatment benefit information, please see the **Substance Use Disorder** benefit.

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

The Mental Health Care benefit doesn't cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluation, forensic evaluations, vocational, educational or academic placement evaluations.

NEURODEVELOPMENTAL THERAPY (HABILITATION)

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

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

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

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

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

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

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

This benefit doesn't cover:

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

NEWBORN CARE

Eligible newborns are covered from birth only if enrolled as described in the **Eligibility and When Coverage Begins** sections.

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

Please Note: If the newborn is admitted to an out-of-network medical facility, benefits for inpatient facility

services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from out-of-network providers, please see the **Summary Of Your Costs**.

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

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

Professional Care

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

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

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

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

ORTHOGNATHIC SURGERY (JAW AUGMENTATION OR REDUCTION)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) are provided. Covered services include repair of a dependent child's congenital anomaly. These procedures are not covered under other benefits of this plan.

PREMERA-DESIGNATED CENTERS OF EXCELLENCE PROGRAM

Premera is working on your behalf to deliver better service excellence and better quality outcomes for services. To accomplish this, Premera has selected providers that have agreed to be held accountable for care quality, experience and cost. Premera calls these providers Designated Centers of Excellence. These providers can give you high quality care for complex medical situations. Designated Centers of Excellence are located throughout the United States.

You will have lower out-of-pocket costs when you receive the covered surgeries below from a Designated Center of Excellence. Please see the **Summary of Your Costs** for the cost-shares you pay.

How to Obtain Coverage

Members must work with Premera and the Designated Center of Excellence to ensure that their treatment is coordinated and consistent with established standards of medical care. Contact Customer Service to be connected with a Premera Personal Health Support Clinician to begin the process.

Like many elective procedures, the surgeries covered under this benefit require prior authorization from Premera to ensure the procedure is a medically appropriate option for you. If you do not receive prior authorization, this plan will not cover the services, and you will have to pay the total cost for the services. See **Prior Authorization** to find out how to request prior authorization.

Once you are given approval for the services, Premera will refer you to the Designated Center of Excellence closest to your home.

Covered Surgeries:

Total Knee and Hip Joint Replacements

Total replacements of joints other than your knee or hip, partial knee or hip replacements, and other knee or hip surgery are covered under other benefits of this plan.

Spinal Surgery

This benefit covers certain spinal surgeries, such as cervical fusion.

Cardiac Surgery

Bariatric Surgery

Please see the **Bariatric Surgery** benefit for details about this coverage.

Covered Services

Services provided by the Designated Center of Excellence and covered under this benefit include pre-operative services and supplies before the procedure, surgery and associated facility care. Post-surgery care is covered under this benefit for a limited period after surgery.

All other related services, including outpatient follow-up care after surgery, rehabilitation and skilled nursing facility care, are subject to the plan's standard cost-shares and are covered under other plan benefits. See the **Summary of Your Costs** for cost-shares for those services.

Travel

Benefits are provided for certain travel expenses related to services provided by a Designated Center of Excellence that are arranged by Premera's travel partner. See **Medical Transportation** for details.

PRESCRIPTION DRUG

What's Covered

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

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

that may work in the same way, have a similar chemical structure, or may be used to treat the same conditions or group of conditions.)

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

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

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

Diabetic Drugs

Shots You Give Yourself

- Prescribed drugs for shots that you give yourself, such as insulin
- Needles, syringes, alcohol swabs, test strips, testing agents and lancets. **Please note:** Your calendar year deductible and coinsurance is waived for syringes when insulin or non-insulin hypoglycemic agents are dispensed first and on the same day. Otherwise your calendar year deductible and coinsurance will apply.

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

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

Glucagon and Allergy Emergency Kits

Prescription Vitamins

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

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

PV1 Preventive Drugs The plan also covers drugs on our PV1 list. PV1 drugs are effective in controlling health problems such as heart disease. Our Pharmacy Committee reviews the list throughout the year. They update the PV1 list when needed. The review process is the same as the process described in "Questions And Answers About Your Pharmacy Benefits" later in this benefit.

Please call customer service or log in to the member portal on our Web site to find out if a drug is on the PV1 list. The phone number and our Web address are on the back of this booklet.

Preventive Drugs Required By The Affordable Care Act that your doctor prescribes

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

Drug uses that are not recognized by one of the above standard drug reference guides can be covered if they are recognized by the Secretary of the US Health and Human Services department or by the majority of

relevant, peer-reviewed medical literature. For more details, see the definition of “prescription drug” in the **Definitions** section of this booklet.

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

Infertility drugs, for fertility treatment or assisted reproduction procedures

Erectile dysfunction/Impotence

GETTING PRESCRIPTIONS FILLED
It is always a good idea to show your Premera Blue Cross ID card when you go to the pharmacy. See question 6 of **Questions And Answers About Your Prescription Drug Benefits** for exceptions to the supply limits shown in this table.

Pharmacy	Supply Limit	Instructions
In-Network Retail Pharmacies (Out-Of-Network retail pharmacies are not covered)	30 days	Pay the cost-share in the Summary Of Your Costs at the pharmacy
In-Network Mail-Order Pharmacy (Out-Of-Network mail-order pharmacies are not covered)	90 days	<ul style="list-style-type: none"> • Allow 2 weeks for your prescription to be filled. • Ask your doctor to prescribe up to a 90-day supply of the drug you need. • Send your prescriptions and a pharmacy mail-order form to the mail order pharmacy. You can download the form from our website or call us for a copy. Our website and phone numbers are on the back cover of this booklet.
In-Network Specialty Pharmacies	30 days	Pay the cost-share in the Summary Of Your Costs at the pharmacy

Exclusions

This benefit does not cover:

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

- Medical equipment and supplies that are not listed as covered above. See the **Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies** benefit for coverage.
- Immunization agents and vaccines. See the **Preventive Care** benefit.

Questions And Answers About Your Prescription Drug Benefit

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

Essentials Drug List

This plan makes use of our Essentials drug list, sometimes called a “formulary.”

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

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

The plan also doesn’t cover certain categories of drugs. These are listed under **Exclusions** earlier in this benefit.

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

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

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

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

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

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

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

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

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

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

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

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

Our Pharmacy and Therapeutics Committee reviews the pharmacy drug list frequently throughout the year. The committee may also add or remove a drug from the Essentials drug list during the year. These changes can happen if new drugs appear on the market or new medical studies or other clinical information warrant the change.

We will tell you if a drug you are taking is going to be removed from the Essentials drug list.

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

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can only be changed at the sole discretion of the Group. The plan's rules about substitution of generic drugs are described above in question 1.

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

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

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

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

Yes. You may have lower out-of-pocket costs when you have your prescriptions filled by in-network pharmacies. This is because in-network pharmacies accept our allowed amount for covered drugs as payment in full. The majority of retail pharmacies in Washington are part of our pharmacy network. Your benefits do not cover prescription drugs dispensed from an out-of-network pharmacy.

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

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

6. How many days' supply of most medications can I get?

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies are described in the **Getting Prescriptions Filled** table above.

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

- The number of units and days' supply dispensed on the last refill

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

Exceptions to the supply limit are allowed:

- A pharmacist can approve an early refill of a prescription for eye drops or eye ointment in some cases.
- A different supply can be allowed so that a new drug can be refilled at the same time as drugs that you are already taking. We will pro-rate the cost-shares to the exact number of days early that the refill is dispensed.

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 consultation with a pharmacist, diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Drug Discount Programs

Pharmacy Benefit Drug Program For pharmacy benefit claims, Premera Blue Cross will pay the Group a prescription drug rebate payment equal to a specific amount per paid brand-name prescription drug claim. Prescription drug rebates Premera Blue Cross receives from its pharmacy benefit manager in connection with Premera Blue Cross's overall pharmacy benefit utilization may be more or less than the Group's rebate payment. The Group's rebate payment shall be made to the Group on a calendar year quarterly basis unless agreed upon otherwise.

The allowed amount for prescription drugs may be higher than the price paid to the pharmacy benefit manager for those prescription drugs.

Premera Blue Cross and the Group agree that the difference between the allowed amount for prescription drugs and the price paid to the pharmacy benefit manager, and the prescription drug payments received by Premera Blue Cross from its pharmacy benefit manager, constitutes Premera Blue Cross property, and not part of the compensation payable under Premera Blue Cross's contract with the Group, and that Premera Blue Cross is entitled to retain and shall retain such amounts and may apply them to the cost of its operations and the pharmacy benefit.

Medical Benefit Drug Program The medical benefit drug program is separate from the pharmacy program. It includes claims for drugs delivered as part of medical services. For medical benefit drug claims, Premera Blue Cross may contract with subcontractors that have rebate contracts with various manufacturers. Rebate subcontractors retain a portion of rebates collected as rebate administration fees. Premera Blue Cross retains a portion of the rebate and describes the medical benefit drug rebate in the Group's annual accounting report. The Group's medical benefit drug rebate payment shall be made to the Group on an annual basis when the rebate is \$500 or more. If less than \$500, Premera will retain the medical benefit drug rebates.

PREVENTIVE CARE

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

Preventive Exams

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

Immunizations

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

Screening Tests

Routine lab tests and imaging, such as:

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

Pregnant Women's Care

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

Colon Cancer Screening

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

- Barium enema
- Colonoscopy, sigmoidoscopy and fecal occult blood tests. The plan also covers a consultation before the colonoscopy and anesthesia your doctor thinks is medically necessary.
- If polyps are found during a screening procedure, removing them and lab tests on them are also covered as preventive.

Diabetes Screening

Health Education and Training

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

Nicotine Habit-Breaking Programs

Programs to stop smoking, chewing tobacco or taking snuff.

Nutritional Counseling and Therapy

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

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

Fall Prevention

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

of falling or have mobility issues

Birth Control

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

Aspirin (OTC) with a prescription for those at risk due to heart conditions or for pregnant women who are at high risk for preeclampsia (75-325mg).

About Preventive Care

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

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

Please go to this government website for more information:

<https://www.healthcare.gov/coverage/preventive-care-benefits/>

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

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

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

For example:

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

The Preventive Care benefit does not cover:

- Take-home drugs or over-the-counter items. Please see **Prescription Drug**.
- Routine newborn exams while the child is in the hospital after birth. Please see **Newborn Care**.
- Routine or other dental care
- Routine vision and hearing exams
- Gym fees or exercise classes or programs

- Services or tests for a specific illness, injury or set of symptoms. Please see the plan's other benefits.
- Physical exams for basic life or disability insurance
- Work-related disability or medical disability exams
- Purchase of hospital-grade breast pumps.
- Male sterilization. Please see **Surgery**.

PROFESSIONAL VISITS AND SERVICES

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

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

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

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

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

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

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

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

The Professional Visits And Services benefit doesn't cover:

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services
- Electronic visits (e-visits)

PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING

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

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

REHABILITATION THERAPY

This plan covers rehabilitation therapy. Benefits must be provided by a licensed physical therapist,

occupational therapist, speech language pathologist or a licensed qualified provider.

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

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

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

Inpatient Care

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

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

Outpatient Care

This benefit covers the following types of outpatient therapy:

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

This benefit does not cover:

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

SELECT BLUE DISTINCTION CENTERS PLUS

Your health plan gives you access to providers that have shown expertise and positive outcomes for certain spinal surgeries and certain types of cellular immunotherapy and gene therapy. Premera Blue Cross calls these providers Blue Distinction Centers Plus.

There are a few Select Blue Distinction Centers Plus throughout the United States. When you use these providers and facilities, your cost-shares will be lower than for other Blue Distinction Centers Plus or Heritage providers. Please see the **Summary Of Your Costs** to find out what your cost-shares are.

Please call Customer Service to find out what providers are covered under this benefit.

Important Note: Services for conditions other than the specific spinal surgeries, cellular immunotherapy or gene therapy procedures covered under this benefit will be subject to your regular cost-shares, even if provided by a Blue Distinction Center Plus.

Premera Blue Cross will work with your doctor and the Blue Distinction Center Plus to coordinate your care.

Travel and Lodging for Select Blue Distinction Centers Plus

If you live more than 50 miles from a Select Blue Distinction Center Plus, the plan will cover travel and lodging necessary to get treatment from the nearest Select Blue Distinction Center Plus that can treat you, up to the maximum stated in the **Summary Of Your Costs**.

Premera Blue Cross must approve the travel prior to departure.

- For spinal surgeries, Premera Blue Cross will arrange travel and lodging for you.
- For cellular immunotherapy and gene therapy, Premera Blue Cross may be able to assist with your travel and lodging arrangements. You may need to submit a claim to have your covered expenses reimbursed.

Benefits are provided for the following:

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

Travel benefits include transportation between the airport and the Select Blue Distinction Center Plus.

- **Lodging:** Hotel, motel or other lodging for stays away from home.
- **Companions:** Travel and lodging for 1 companion is covered if the companion has to come with the member due to medical necessity or safety. For a child under age 19, the plan will cover one companion automatically. Costs for a second companion are only covered when medically necessary.
- **Limits:** The plan covers travel and lodging costs according to IRS guidelines. Lodging expenses will be reimbursed but expenses above the IRS limits will be reported to the Group and the subscriber for tax purposes. The per day limits and requirements can change if IRS regulations change. Please go to the IRS website, **www.irs.gov**, for details. This summary is not and should not be assumed to be tax advice.
- **Costs Not Covered**
 - Travel to a provider that is not a Select Blue Distinction Center Plus. This includes travel to other Blue Distinction Centers Plus.
 - Travel that is not approved by Premera Blue Cross, even if the doctor refers you.
 - Meals
 - Lodging at a family member's or friend's home
 - Alcohol or tobacco
 - Car rental
 - Entertainment, such as movies, visits to museums, or mileage for sightseeing
 - Costs for people other than you and your covered companion(s)
 - Costs for pets or animals, other than service animals
 - Personal care items, such as shampoo or a toothbrush
 - Tourist items, such as T-shirts, sweatshirts, or toys
 - Phone calls

SKILLED NURSING FACILITY SERVICES

This benefit includes:

- Room and board

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

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

This benefit does not cover:

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

SPINAL AND OTHER MANIPULATIONS

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

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

SUBSTANCE USE DISORDER

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services.

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

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

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

The Substance Use Disorder benefit doesn't cover:

- Treatment of alcohol or drug use or abuse that does not meet the definition of "Chemical Dependency" as stated in the **Definitions** section of this booklet
- Halfway houses, quarterway houses, recovery houses, and other sober living residences

SURGERY

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

- Anesthesia or sedation and postoperative care as medically necessary.
- Cornea transplantation, skin grafts, repair of a dependent child's congenital anomaly, and the transfusion of blood or blood derivatives.
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify

as preventive services as described in the **Preventive Care** benefit.

- Surgery that is medically necessary to correct the cause of infertility. This does not include assisted reproduction techniques or sterilization reversal.
- Repair of a defect that is the direct result of an injury, providing such repair is started within 12 months of the date of the injury.
- Correction of functional disorders upon our review and approval.
- Vasectomy

SURGICAL CENTER CARE – OUTPATIENT

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

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

For services to change gender, please see the **Transgender Services** benefit.

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

TEMPOROMANDIBULAR JOINT DISORDERS (TMJ) CARE

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

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

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

This benefit covers:

- Exams
- Consultations
- Treatment

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

- X-rays (see **Diagnostic X-Ray, Lab and Imaging**)
- Surgery (See **Surgery**)
- Hospital (See **Hospital**)

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

THERAPEUTIC INJECTIONS

This benefit covers:

- Shots given in the doctor's office
- Supplies used during the visit, such as serums, needles and syringes
- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

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

TRANSGENDER SERVICES

This benefit covers medically necessary services to change the gender you were born with. To find the amounts you are responsible for, please see the **Summary Of Your Costs**.

This benefit covers services which meet the standards in our medical policy. Call Customer Service or visit our website at **www.premiera.com** for the policy.

See the **Surgery** benefit for gynecological, urologic and genital surgery for covered conditions other than gender identity disorder or gender dysphoria.

See the **Prescription Drug** benefit for coverage of prescription drugs associated with transgender procedures.

See the **Mental Health Care** benefit for coverage of mental health services.

This benefit does not cover:

- Transgender surgery for members under 18
- Cosmetic procedures that are not medically necessary to make the gender change. Examples are hair removal and procedures to change the voice.
- Surgery to change the appearance of prior gender change procedures except when medically necessary to correct medical complications.

TRANSPLANTS

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

Covered Transplants

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

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

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

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

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

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

- Your medical condition must meet the plan's written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An “approved transplant center” is a hospital or other provider that’s developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and meets the approval standards we use.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we’ll direct you to an approved transplant center that we’ve contracted with for transplant services.

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

Recipient Costs

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

Donor Costs

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

Travel And Lodging

Benefits are provided for certain travel expenses related to services provided by an approved transplant provider that are arranged by Premera’s travel partner. See **Medical Transportation** for details.

The Transplants benefit doesn’t cover:

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

URGENT CARE

This benefit covers:

Exams and treatment of:

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

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

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

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

VIRTUAL CARE – ON DEMAND

On demand virtual care provides ease, convenience and immediate access to medical care for limited low-level acute medical conditions such as a urinary tract infection or strep throat using several technology solutions. This benefit covers on-demand virtual care using secure chat, text, voice or audio messaging, and video chat.

This benefit does not cover real-time visits between you and your doctor via online and telephonic methods (telemedicine). See the **Professional Visits And Services** and **Mental Health Care** benefits.

VISION CARE

Vision Exams

This benefit provides for routine vision exams by an ophthalmologist or optometrist as stated in the **Summary Of Your Costs**. Covered routine exam services include:

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

The **Vision Exam** benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

Some clinics that are based in or owned by a hospital charge a separate facility fee for all physician visits, including routine vision exams. Benefits for these fees will be subject to your calendar year deductible and coinsurance, if any.

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

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

Vision Hardware

For Members 19 Or Older

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

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

The Vision Hardware benefit covers:

- Prescription eyeglass lenses (single vision, bifocal, trifocal, progressive), quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes
 - Vision hardware benefits are based on the "allowed amount" (please see the **Important Plan Information** section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

For members 19 or older, the Vision Hardware benefit doesn't cover:

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

Members Under 19

The Vision Hardware benefit will provide coverage as shown in the **Summary Of Your Costs** until the end of the month in which the member turns 19.

WEIGHT MANAGEMENT

Surgical Weight Loss Treatment

Benefits for hospital and professional treatment of morbid obesity are covered the same as any other covered

condition subject to the criteria listed below, applicable benefits, limitations and exclusions.

Coverage includes:

- One surgical procedure including complications directly related to the surgery
- Pre-surgical visits
- Related outpatient services, and
- One follow-up visit

This benefit will be provided only when covered services are furnished by a Blue Distinction Centers Plus Facility. If the expenses are not incurred at a Blue Distinction Center, no payment will be made.

Weight loss surgery also requires prior authorization. See **Prior Authorization** later in this booklet.

To qualify for the surgical treatment for morbid obesity benefit, the member must meet the three criteria stated in the Claims Administrator's medical policy on bariatric surgery. A summary of these criteria is shown below. Please see the Bariatric Surgery medical policy at www.Premera.com. Click the link to Medical Policies at the bottom of the landing page.

1. The member must be diagnosed as one of the following:

- Morbidly obese with a Body Mass Index (BMI) greater than 40; or
- Overweight with a BMI greater than 35 with at least one of the following conditions, including but not limited to:
 - Established coronary heart disease
 - Other atherosclerotic disease
 - Type 2 diabetes that is not controlled by drug therapy
 - High blood pressure that is not controlled by medical management
 - Sleep apnea documented as moderate or severe

2. During the 2 years immediately before the surgery, the member has actively taken part in a weight-loss program that is supervised by a physician and that lasted at least 6 months in a row. The program must be documented in the member's medical records.

3. A licensed mental health provider has evaluated the member to establish emotional stability and ability to cope with surgical limitations

For specific surgical treatment benefit information, please see the Hospital Inpatient Care, Hospital Outpatient Care and Surgical Services benefits.

Travel and Lodging for Select Blue Distinction Centers Plus

If you live more than 50 miles from a Select Blue Distinction Center Plus, the plan will cover travel and lodging necessary to get treatment from the nearest Select Blue Distinction Center Plus that can treat you, up to the maximum stated in the **Summary Of Your Costs**.

Premera Blue Cross must approve the travel prior to departure.

Benefits are provided for the following:

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

Travel benefits include transportation between the airport and the Select Blue Distinction Center Plus.

- **Lodging:** Hotel, motel or other lodging for stays away from home.

- **Companions:** Travel and lodging for 1 companion is covered if the companion has to come with the member due to medical necessity or safety. For a child under age 19, the plan will cover one companion automatically. Costs for a second companion are only covered when medically necessary.
- **Limits:** The plan covers travel and lodging costs according to IRS guidelines. Lodging expenses will be reimbursed but expenses above the IRS limits will be reported to the Group and the subscriber for tax purposes. The per day limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be assumed to be tax advice.
- **Costs Not Covered**
 - Travel to a provider that is not a Select Blue Distinction Center Plus. This includes travel to other Blue Distinction Centers Plus.
 - Travel that is not approved by Premera Blue Cross, even if the doctor refers you.
 - Meals
 - Lodging at a family member's or friend's home
 - Alcohol or tobacco
 - Car rental
 - Entertainment, such as movies, visits to museums, or mileage for sightseeing
 - Costs for people other than you and your covered companion(s)
 - Costs for pets or animals, other than service animals
 - Personal care items, such as shampoo or a toothbrush
 - Tourist items, such as T-shirts, sweatshirts, or toys
 - Phone calls

The Weight Management benefit does not cover:

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

WELLNESS-BASED PROGRAMS

EMPLOYEE ASSISTANCE PROGRAM

Members have access to a separate Employee Assistance Program through ComPsych that provides a 24-hour toll-free line to speak immediately with Masters level intake counselors who can refer the member to a local state-licensed mental health clinician. Members will also have access to online resources for legal, financial, and family issues, as well as common stressors of daily life. For more information on the services provided through the program, call ComPsych directly at 1-844-862-0898.

INTERACTIVE DIGITAL SELF-CARE PLATFORM

Members will also have access to interactive Computerized Cognitive Behavioral Therapy (CCBT) through ComPsych. These CCBT resources include guided programs on anxiety, chronic pain, depression, mindfulness, substance abuse and much more. The CCBT resources can be accessed at:

<https://www.guidanceresources.com/groWeb/login/login.xhtml>

These programs are offered separately by Premera partners and are not considered to be benefits under this plan. We periodically review the participation and effectiveness of our wellness-based programs and may alter the programs from time to time. We or our health partner will notify you in advance of any changes to our programs.

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

OUT-OF-AREA CARE

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

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

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

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

BlueCard Program

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

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

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

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

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

BlueCard in California We have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross of California. In order for you to maximize your savings under the BlueCard Program, you will need to choose only Anthem Blue Cross of California network providers for services received in California.

Please see "How Does Selecting A Provider Affect My benefits?" for further details on how to lower your out-of-pocket expenses.

Value-Based Programs You might have a provider that participates in a Host Blue's value-based program (VBP). Value-based programs focus on meeting standards for treatment outcomes, cost and quality, and for coordinating care when you are seeing more than one provider. The Host Blue may pay VBP providers for meeting the above standards. If the Host Blue includes charges for these payments in the allowed amount for a claim, you would pay a part of these charges if a deductible or coinsurance applies to the claim. If the VBP

pays the provider for coordinating your care with other providers, you will not be billed for it.

Taxes, Surcharges and Fees

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

Non-Contracted Providers

It could happen that you receive covered services from providers outside our service area that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. Please see **Allowed Amount** in this booklet for details on allowed amounts.

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

Blue Cross Blue Shield Global® Core

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

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

More Questions

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

CARE MANAGEMENT

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

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

PRIOR AUTHORIZATION

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

There are two different types of prior authorization required:

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

HOW PRIOR AUTHORIZATION WORKS

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

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

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

1. PRIOR AUTHORIZATION FOR BENEFIT COVERAGE

Medical Services, Supplies or Equipment

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

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

It is a good idea to ask Premera for prior authorization when you see a non-contracted provider. It is to your advantage to know ahead of time if the plan is not going to cover a service, equipment, or an inpatient stay.

Prescription Drugs

The plan has a specific list of prescription drugs that must have prior authorization before you get them at a pharmacy. The list is on our website at **premera.com**. Your provider can ask for a prior authorization by

faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website.

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

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

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

- A set number of days' supply or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis
- Certain drugs from certain pharmacies, or you may need to get a prescription drug from an appropriate medical specialist or a specific provider
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

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

Exceptions To Prior Authorization For Benefit Coverage

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

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

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

2. PRIOR AUTHORIZATION FOR OUT-OF-NETWORK PROVIDER COVERAGE

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

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

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

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

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

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

Exceptions To Prior Authorization For Out-of-Network Providers

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

If you are admitted to an out-of-network hospital due to an emergency condition, those services are always covered at the in-network benefit level. The plan will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital. **In addition to the plan's cost shares, you will be required to pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Any amounts you pay over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.**

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

CLINICAL REVIEW

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

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

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

PERSONAL HEALTH SUPPORT PROGRAMS

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

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

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

EXCLUSIONS

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

Amounts Over The Allowed Amount

This plan does not cover amounts over the allowed amount as defined by this plan. If you get services from a non-contracted provider, you will have to pay any amounts for your services that are over the allowed amount.

Benefits From Other Sources

This plan does not cover services that are covered by liability insurance, motor vehicle insurance, excess coverage, no fault coverage, or workers compensation or similar coverage for work-related conditions. For details, see **Third Party Recovery** under **What If I Have Other Coverage**.

Benefits That Have Been Exhausted

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

Broken Or Missed Appointments

Charges For Records Or Reports

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

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, this plan does not cover personal services or items such as meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport. This does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Dietary assistance, including "Meals on Wheels"

Complications

This plan does not cover complications of a non-covered service, including follow-up services or effects of those services, except services defined as emergency care. See **Definitions**.

Cosmetic Services

The plan does not cover drugs, services or supplies for cosmetic services. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

Counseling, Education And Training

This plan does not cover counseling and, education or training in the absence of illness. This includes but is not limited to:

- Job help and outreach, social or fitness counseling
- Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education

program or should otherwise be provided by school staff.

- Private school or boarding school tuition

Court-Ordered Services

This plan does not cover services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Custodial Care

This plan does not cover custodial care but see **Hospice Care**.

Dental Care

This plan does not cover dental care that is not addressed under **Dental Care**, **Chemotherapy And Radiation Therapy**.

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

Donor Breast Milk

Environmental Therapy

This plan does not cover therapy designed to provide a changed or controlled environment.

Experimental Or Investigative Services

This plan does not cover any service or supply that is experimental or investigative, see **Definitions**.

Family Members Or Volunteers

This plan does not cover services or supplies that you give furnish to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer, except as described in **Home Health Care** and **Hospice Care**

Governmental Facilities

This plan does not cover services provided by a state or federal hospital which is not an in-network facility that are not emergency care or required by law or regulation.

Hair Analysis

Hair Loss

This plan does not cover:

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

Hearing Exams

This plan does not cover routine hearing exams and testing used to prescribe or fit hearing aids and any associated service or supply.

Hearing Hardware

This plan does not cover hearing aids and devices used to improve hearing sharpness and any associated service or supply. However, the plan does cover medically necessary cochlear implants as shown in the ***Surgery*** and ***Rehabilitation Therapy*** benefits.

Hospital Admission Limitations

This plan does not cover hospital stays solely for the diagnostic studies, physical examinations, checkups, medical evaluations or observations, unless:

- The service cannot be provided without the use of a hospital
- You have a medical condition that makes hospital care medically necessary

Illegal Acts and Terrorism

This plan does not cover illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt.

Laser Therapy

Benefits are not provided for low-level laser therapy.

Military Service And War

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

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units.

Non-Covered Services

This plan does not cover services or supplies:

- Ordered when this plan is not in effect or when the person is not covered under this plan
- Provided to someone other than the ill or injured member, other than outpatient health education services covered under the ***Preventive Care*** benefit. This includes health care provider training or educational services.
- Directly related to any condition, or related to any other service or supply, that is not covered
- You are not required to pay or would not have been charged for if this plan were not in force
- That are not listed as covered under this plan

Non-Treatment Charges

- Charges for provider travel time
- Transporting a member in place of a parent or other family member, or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.

Non-Treatment Facilities, Institutions Or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, and juvenile detention facilities. Benefits are provided for medically necessary treatment received in these locations. See ***Covered Services*** for specific benefit information.

Not Medically Necessary

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

Orthodontia

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

Provider's Licensing Or Certification

This plan does not cover services that the provider's license or certification does not allow him or her to perform. It also does not cover a provider that does not have the license or certification that the state requires. The only exception is for applied behavior analysis providers covered under ***Mental Health Care and Substance Use Disorder***. See ***Definitions*** for provider details.

Recreational, Camp And Activity Programs

This plan does not cover recreational, camp and activity-based programs. These programs are not medically necessary and include:

- Gym, swim and other sports programs, camps and training
- Creative art, play and sensory movement and dance therapy
- Recreational programs and camps
- Boot camp programs
- Equine programs and other animal-assisted programs and camps
- Exercise and maintenance-level programs

Serious Adverse Events and Never Events

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

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

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

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

Services or Supplies For Which You Do Not Legally Have To Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants. The only exception is for certain drugs to treat impotence. See the ***Summary Of Your Costs*** and ***Prescription***

Drugs for details.

Vision Therapy

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

Voluntary Support Groups

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

Weight Loss Drugs

This plan does not cover drugs or supplements for weight loss or weight control. This is true even if you have an illness or injury that might be helped by weight loss drugs.

Work-Related Illness Or Injury

This plan does not cover any illness, condition or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see **Third Party Recovery** under **What If I Have Other Coverage**.

WHAT IF I HAVE OTHER COVERAGE?

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

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

You also may be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a "coordination of benefits" feature to handle such situations.

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

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

DEFINITIONS APPLICABLE TO COORDINATION OF BENEFITS

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. For the purposes of this plan, only those dental services to treat an injury to natural teeth will be considered an allowable dental expense.
- **Claim Determination Period** means a calendar year.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.
- **Medical Plan** means all of the following health care coverages, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents
 - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation
 - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease

- **Dental Plan** means all of the following dental care coverages, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents

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

EFFECT ON BENEFITS

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." When this plan is secondary, it will reduce its benefits for each claim so that the benefits from all medical plans aren't more than the allowable medical expense for that claim and the benefits from all dental plans aren't more than the allowable dental expense for that claim.

We will coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

PRIMARY AND SECONDARY RULES

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

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

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

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

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

- **Birthdate rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
 - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. If the parent who is responsible has no health coverage for the dependent, but that parent's spouse does, that spouse's plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.

- If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
- If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
 - The plan covering the custodial parent, first
 - The plan covering the spouse of the custodial parent, second
 - The plan covering the non-custodial parent, third
 - The plan covering the spouse of the non-custodial parent, last
 - If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

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

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

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

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

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

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

Right Of Recovery/Facility Of Payment

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

THIRD PARTY RECOVERY

GENERAL

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

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

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

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

DEFINITIONS

The following definitions shall apply to this section:

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

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

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

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

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

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

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

EXCLUSIONS

- **Benefits From Other Sources** Benefits are not available under this plan when coverage is available through:
 - Motor vehicle medical or motor vehicle no-fault
 - Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage, or

Medical Premises coverage

- Boat coverage
- School or athletic coverage
- Any type of liability insurance, such as home owners' coverage or commercial liability coverage
- Any type of excess coverage
- **Work-Related Illness Or Injury**

This plan does not cover any illness, condition or injury, for which you get benefits under:

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

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

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

REIMBURSEMENT AND SUBROGATION RIGHTS

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

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

means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.

The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.

- You cannot assign any rights or causes of action that you might have against a third-party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

YOUR RESPONSIBILITIES

- If any of the requirements below are not met, the plan shall:
 - Deny or delay claims related to your injury
 - Recoup directly from you all benefits the plan has provided for your injury
 - Deduct the benefits owed from any future claims
- You must notify Premera Blue Cross of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information. Neither the plan nor Premera Blue Cross shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

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

REIMBURSEMENT AND SUBROGATION PROCEDURES

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

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

- Initiating an action against you and/or your lawyer to compel compliance with this section.
- Withholding plan benefits payable to you or your family until you and your lawyer complies or until the reimbursement amount has been fully paid to the plan.

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

Step 1

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

Step 2

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

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

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

Prescription Drug Claims

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

In-Network Pharmacies

For retail pharmacy purchases, you don't have to send us a claim. Just show your Premera Blue Cross ID card to the pharmacist, who will bill us directly. If you don't show your ID card you'll need to fill out a prescription

drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

Out-Of-Network Pharmacies

Your benefits do not cover prescription drugs dispensed from an out-of-network pharmacy.

Please note: You'll have to pay the full cost for all new prescriptions and refills.

TIMELY FILING

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

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

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

SPECIAL NOTICE ABOUT CLAIMS PROCEDURE

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

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

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

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

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

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

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

COMPLAINTS AND APPEALS

We know healthcare doesn't always work perfectly. Our goal is to listen, take care of you, and make it simple. If it doesn't go the way you expect, you have two options:

- Complaint – is when you are not satisfied with customer service or with the quality of or access to medical care. You can call Customer Service if you have a complaint. We may ask you to send the details in writing. We will send a written response within 30 days.
- Appeal – is a request to review of a specific decision we have made.

WHAT YOU CAN APPEAL

Claims and Prior Authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials. It also includes denials of drugs not on the plan's list of covered drugs. (See Prescription Drug for details)
Enrollment canceled or not issued	No Coverage	You are not eligible to enroll or stay in the plan

These are examples of adverse benefit determinations. Please see Definitions for more information.

The rest of this section will explain the appeal process. If you still have questions, please call Customer Service. Contact information is on the back of your Premera ID card.

APPEAL LEVELS

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified of our Level 1 appeal decision.
External	If we deny your Level 2 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	Four months from the date you were notified of our Level 2 appeal decision. OR Four months from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL

Here are your options for submitting an appeal:

- Submit an appeal form – go to premera.com to access our appeal form. You have the option of attaching additional documentation and a written statement.

- Call Customer Service to submit your appeal. See your Premera ID card for the phone number.
- Write to us at the address listed on the back of this booklet.

Submit supporting documentation. This may include chart notes, medical records, or a letter from your doctor.

If you need help filling out an appeal, or would like a copy of the appeals process, please call Customer Service.

If you would like to review the information used for your appeal, please call Customer Service. The information will be sent as soon as possible and free of charge.

Choose Someone To Appeal For You

Choose someone, including your doctor, to appeal on your behalf. **To choose someone else, complete a Member Appeal Form with Authorization located on premera.com.** We can't release your information without this form. You do not need an authorization if your provider is contracted with Premera.

Appeal Response Time Limits

We'll review your appeal and send a decision within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, a group of people who have not reviewed the case before will review and make a decision.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 15 days
All other appeals	15-30 days
External appeals	<ul style="list-style-type: none"> • Urgent appeals within 72 hours • Other IRO appeals within 45 days after the IRO gets the information

WHAT HAPPENS IF YOU HAVE ONGOING CARE

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

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

WHAT HAPPENS IF IT'S URGENT

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

Examples of urgent situations are:

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

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

HOW TO ASK FOR AN EXTERNAL REVIEW

- We will tell you about your right to an external review with the written decision of your internal appeal. Go to **premera.com** to access our external appeal form. You may also write to us directly to ask for an external appeal.
- Please include the signed external appeal form. You may also include medical records and other information.

We will forward your medical records and other information to the Independent Review Organization (IRO). If you have additional information on your appeal, you may send it to the IRO.

ONCE THE IRO DECIDES

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

If the IRO:

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

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

You can also contact the Employee Benefits Security Administration of the U.S. Department of Labor. The phone number is 1-866-444-EBSA (3272).

OTHER INFORMATION ABOUT THIS PLAN

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

CONFORMITY WITH THE LAW

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

EVIDENCE OF MEDICAL NECESSITY

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

HEALTHCARE PROVIDERS — INDEPENDENT CONTRACTORS

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

INTENTIONALLY FALSE OR MISLEADING STATEMENTS

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

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

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

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

MEMBER COOPERATION

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

NOTICE OF INFORMATION USE AND DISCLOSURE

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

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

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

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

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

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

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

NOTICE OF OTHER COVERAGE

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

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

NOTICES

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

RIGHT OF RECOVERY

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

RIGHT TO AND PAYMENT OF BENEFITS

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

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

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

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

VENUE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Please see ***Covered Services***.

ERISA PLAN DESCRIPTION

The following information has been provided by Weyerhaeuser to meet ERISA requirements for the summary plan description.

When used in this section, the term "ERISA plan" refers to Weyerhaeuser's employee welfare benefit plan. The "ERISA plan administrator" is Weyerhaeuser. Premera Blue Cross is **not** the ERISA plan administrator.

Weyerhaeuser has an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the "ERISA plan" in this section. The Premera Blue Cross plan described in this booklet is part of the ERISA plan.

ERISA gives subscribers and dependents the right to a summary describing the ERISA plan. The ERISA plan details below, together with the information contained throughout this benefit booklet, make up the "summary plan description" required by ERISA for that portion of the ERISA plan administered by Premera Blue Cross. This booklet is also a part of the contract between Weyerhaeuser and Premera Blue Cross.

Name of Plan

Medical Plus Plan, which is a part of the Weyerhaeuser Company Health and Welfare Plan

Name and Address of Employer & Plan Sponsor

Weyerhaeuser Company
Weyerhaeuser Compensation & Benefits
220 Occidental Ave S.
Seattle, WA 98104
800-833-0030

Subscribers and dependents may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the ERISA plan and, if so, the sponsor's address.

Employer Identification Number "EIN"

91-0470860

Plan Number

577

Type of Plan

Employee welfare benefit plan providing health care coverage

Type of Administration

Third-Party through Premera Blue Cross

Name, Address, and Telephone Number of ERISA Plan Administrator

Weyerhaeuser Company Administrative Committee
Weyerhaeuser Compensation & Benefits
220 Occidental Ave S.
Seattle, WA 98104
800-833-0030

Agent for Service of Legal Process

Weyerhaeuser Company
Corporate Secretary
Law Department
220 Occidental Ave S.
Seattle, WA 98104
800-833-0030

Service of legal process may also be made on the ERISA plan Administrator.

Eligibility to Participate in the Plan

Employees and their dependents are eligible for the benefits of the plan when they meet the eligibility requirements in this booklet, are enrolled with Premera Blue Cross as described in this booklet, and all required subscription charges for them are and continue to be paid as required by Weyerhaeuser's contract with Premera Blue Cross.

Benefits

The benefit booklet tells you the terms and limitations of each benefit of this plan. You may have lower out-of-pocket costs if you use providers that have signed contracts with us. This booklet explains the provider networks, when applicable. It also tells how benefits are affected if members do not use these providers. The benefit sections of this booklet also explain what part of the cost of covered health care that you must pay.

Disqualification, Ineligibility or Denial, Loss, Forfeiture, or Suspension Of Any Benefits

This booklet describes circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, reduction, offset or recovery of any benefits for members.

Source of Contributions

The employer and employee share the cost of the subscriber's coverage and the cost of the dependents' coverage. Self-payments are also permitted; please see the "How Do I Continue Coverage?" section in this booklet.

If the contract between us and Weyerhaeuser terminates for any reason, Weyerhaeuser will be liable, up to the limit defined in the contract, for any claims paid on its behalf subsequent to termination.

Funding Medium

Benefits under the plan are self-insured. This means benefit claims are paid directly from Weyerhaeuser's general assets.

Plan Changes and Termination

The "Contract Termination" and "Changes In Coverage" portions of this booklet describe the circumstances when the contract between Weyerhaeuser and Premera Blue Cross may be changed or terminated.

Termination of the contract is not the same as termination of Weyerhaeuser's ERISA plan. Weyerhaeuser may choose to continue its ERISA plan through other insurance contracts or arrangements. However, no rights are vested under the ERISA plan. Weyerhaeuser reserves the right to change or terminate its ERISA plan in whole or in part, at any time, with no liability.

Weyerhaeuser will tell employees if its ERISA plan is changed or terminated. If the ERISA plan were to be terminated, members would have a right to benefits only for covered services received before the ERISA plan's end date.

ERISA Plan Year

The ERISA plan year ends on each December 31st.

WHAT ARE MY RIGHTS UNDER ERISA?

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

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. (The Group has delegated to us the discretionary authority to determine eligibility for benefits and construe the terms used in the plan to the extent stated in our administrative services contract with the Group.) No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

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

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

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

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

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

DEFINITIONS

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

Adverse Benefit Determination

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

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

Affordable Care Act

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

Calendar Year

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

Chemical Dependency (also called "Substance Use Disorder")

An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

Clinical Trials

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:

- An institutional review board that complies with federal standards for protecting human research subjects and
- One or more of the following:
 - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
 - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
 - The United States Department of Defense
 - The United States Department of Veterans' Affairs

- A nongovernmental research entity abiding by current National Institute of Health guidelines

Community Mental Health Agency

An agency that's licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.

Congenital Anomaly Of A Dependent Child

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

Cost-Share

The member's share of the allowed amount for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See the **Summary Of Your Costs** to find out what your cost-share is.

Custodial Care

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

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

Detoxification

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

Effective Date

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

Eligibility Waiting Period

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

Emergency Care

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

Essential Health Benefits

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

Experimental/Investigational Services

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

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

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

Group

The entity that sponsors this self-funded plan.

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A "hospital" will never be an institution that's run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition or pregnancy.

Injury

Physical harm caused by a sudden event at a specific time and place. It's independent of illness, except for infection of a cut or wound.

In-Network Pharmacy (In-Network Retail Pharmacy)

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

In-Network Provider

A provider that is in one of the networks stated in the ***How Providers Affect Your Costs*** section.

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical Emergency (also called "Emergency")

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

Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It's of no use in the absence of illness or injury.

Medical Facility (also called "Facility")

A hospital, skilled nursing facility, state-approved chemical dependency treatment program or hospice.

Medically Necessary

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

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

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

Member (also called “You” and “Your”)

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

Non-Contracted Provider

A provider is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

Obstetrical Care

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

Abortion is included as part of obstetrical care.

Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Out-Of-Network Provider

A provider that is not in one of the provider networks stated in the ***How Providers Affect Your Costs*** section.

Outpatient

Treatment received in a setting other than an inpatient in a medical facility.

Outpatient Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures
- It doesn't provide inpatient services or accommodations

Pharmacy Benefit Manager

An entity that contracts with us to administer the ***Prescription Drug*** benefit under this plan.

Physician

A state-licensed:

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

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

- Chiropractor (D.C.)

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

Plan (also called "This Plan")

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

Prescription Drug

Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

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

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

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

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

Prior Authorization

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

See **Prior Authorization** for details.

Provider

A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

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

Board Certified Behavior Analysts (BCBAs) will be considered health care providers for the purposes of providing applied behavior analysis (ABA) therapy, as long as both of the following are true: 1) They're licensed when required by the State in which they practice, or, if the State does not license behavior analysts, are certified as such by the Behavior Analyst Certification Board, and 2) The services they furnish are consistent with state law and the scope of their license or board certification. Therapy assistants/behavioral technicians/paraprofessionals that do not meet the requirements above will also be covered providers under this plan when they provide ABA therapy and their services are supervised and billed by a BCBA or one of the following state-licensed provider types: psychiatrist, developmental pediatrician, pediatric neurologist, psychiatric nurse practitioner, advanced nurse practitioner, advanced registered nurse practitioner, occupational or speech therapist, psychologist, community mental health agency that is also state-certified to provide ABA therapy.

Psychiatric Condition

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

Service Area

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

Skilled Care

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

Skilled Nursing Facility

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

Subscriber

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

Subscription Charges

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

We, Us and Our

Means Premera Blue Cross.

Where To Send Claims

MEDICAL CLAIMS

Mail Your Medical Claims To

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

Contact the Pharmacy Benefit Manager At:

1-800-391-9701
www.express-scripts.com

Customer Service

MEDICAL BENEFITS

Mailing Address

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

Phone Numbers

Local and toll-free number:
1-800-995-2420

Physical Address

7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Local and toll-free TDD number
for the hearing impaired:
1-800-842-5357

24 Hour Nurseline:

1-800-995-2420

Weyerhaeuser Employee Service Center (ESC) for Enrollment and Eligibility:

1-800-833-0030

WageWorks for COBRA Administration:

1-877-722-2667

Mybenefits.wageworks.com

Care Management

Prior Authorization And Emergency Notification

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

Local and toll-free number:
1-800-722-1471
Fax: 1-800-843-1114

Complaints And Appeals

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

BlueCard

1-800-810-BLUE(2583)

Web Site

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

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

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

Language Assistance

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

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

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

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

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

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

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

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

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

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

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

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

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

ໂປດອຸບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສົ່ງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

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

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

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

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

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

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