



REQUIRED NOTIFICATIONS

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THE WOMEN’S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

	Premera QHDHP		Premera PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Individual Deductible	\$5,000	\$10,000	\$2,000	\$4,000
Family Deductible	\$10,000	\$20,000	\$4,000	\$8,000
Coinsurance	Covered at 100% After deductible	Covered at 50% after deductible. You pay 50%	Covered at 80% after deductible. You pay 20%	Covered at 50% after deductible. You pay 50%

NEWBORNS ACT DISCLOSURE - FEDERAL

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, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 60 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage) and enrollment must be completed within 60 days of the date you became eligible.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption and enrollment must be completed within 60 days of the date of eligibility.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment 60 days from the loss of coverage or the date you become eligible for premium assistance. To request special enrollment or obtain more information, contact person listed at the end of this summary within 30 days of your qualifying event.

Fact Sheet



U.S. Department of Labor
Employee Benefits Security Administration

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the [Frequently Asked Questions](#) (FAQs) About the Newborns' and Mothers' Health Protection Act.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

Premera generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Premera at 1 (855) 629-0987.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Premera.

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you considering your health status.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$156 per day (up to a \$1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If Plan fiduciaries misuse the Plan's money, or if you are 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 are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

**Premium Assistance Under Medicaid and the
Children’s Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
<p>Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
KANSAS – Medicaid	NEBRASKA – Medicaid
<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
KENTUCKY – Medicaid	NEVADA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihip.p.aspx Phone: 1-855-459-6328 Email: KIHIP.PPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid

Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
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To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Gesa Credit Union		4. Employer Identification Number (EIN) 910616262	
5. Employer address 51 Gage BLVD		6. Employer phone number 509-378-3100	
7. City Richland	8. State WA	9. ZIP code 99352	
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above)		12. Email address hrmail@gesa.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees. Eligible employees are:

- Some employees. Eligible employees are:
Employees who meet the ACA definition of full-time.

- With respect to dependents:
 - We do offer coverage. Eligible dependents are:
Dependents who meet the definition of "dependent" per IRS code 152.

- We do not offer coverage.

- If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other

factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

-
- An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



Self-Funded Plan Notice of Privacy Practices

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

The notice describes how medical information about you may be used and disclosed and how you can get access to this information (effective January 1, 2022.) Gesa Credit Union's Self-funded Plan ("The Plan") are committed to protecting your health information. The Plan is required by HIPAA law to maintain the privacy of your medical information by the terms of the most current Notice of Privacy Practices, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. The Plan reserves the right to change the terms of this Notice of Privacy and to make any new Notice provisions effective for all Protected Health information (known as "PHI"). The Plan will inform all participants of changes to this Notice and provide a new and update Notice of Privacy each time a change in content occurs.

I. Confidentiality Practices and Uses

The Plan may access, use or share medical information:

- 1. Treatment.** During the course of your care, Protected Health Information (known as "PHI") may be disclosed to treatment providers as appropriate/necessary to ensure the quality and continuity of your care. The treatment exception allows doctors to share health information about a patient in order to assure that the patient receives proper care.
- 2. Payment.** We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. The Privacy Rule permits The Plan to disclose health information without individual authorization for the purpose of paying a claim.
- 3. Regular Health Care Operations.** To maintain efficient, quality and cost effective medical care, PHI is routinely reviewed by authorized personnel to ensure that the highest quality standards of patient care are consistently being practiced. For example, PHI may be seen by regulatory agencies that oversee clinical laboratories during routine quality assurance procedures. We may also use PHI for underwriting, premium rating, and other activities relating to Plan coverage such as: submitting claims for stop-loss coverage; conducting or arranging for Medical review, legal services, audit services and fraud and abuse detection programs. We will not use your genetic information for underwriting purposes.
- 4. Information Provided Directly to You or Mailed to You.** For example, your medical provider may give you a copy of your lab results or you may receive a bill sent to your address on file for any outstanding balances.
- 5. Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate contracts with us.

II. Disclosures Not Requiring Your Permission

- 1. Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your emergency contact or another person responsible for your care about your location, general condition or in the event of your death. However, if you are able and available to agree or object, we will give you the opportunity to do so prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
- 2. Required by Law.** As required by law, we may use and disclose your health information.
- 3. Public Health.** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the FDA problems with products and reactions to medications; and reporting disease or infection exposure.
- 4. Health Oversight Activities.** We may disclose your health information to business associates, the plan sponsor, health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.
- 5. Judicial and Administrative Proceedings.** We may disclose your health information in the course of any administrative or judicial proceeding.
- 6. Law Enforcement.** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
- 7. Deceased Person Information.** We may disclose your health information to coroners, medical examiners or funeral directors.
- 8. Organ Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
- 9. Research.** We may disclose your health information to researchers conducting research that has been approved.
- 10. Public Safety.** We may disclose your health information to appropriate persons in order to prevent, lessen or coordinate a response to a serious and imminent threat to the health/safety of a particular person, the campus community or the general public.
- 11. Specialized Government Functions.** We may disclose your health information for military, national security, intelligence and/or protective services for the President, prisoner and government benefits required by law.

12. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws.

13. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.

III. Your Rights to Privacy

Except as described in this Notice of Privacy Practices, The Plan will not use or disclose your health information without your written authorization. If you do authorize The Plan to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Human Resources has procedures to assist you with your rights to your medical information. You may ask Human Resources' for a hard copy of this notice at any time.

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: 1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or 2) treating such person as your personal representative could endanger you; and 3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under The Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under The Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes*; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

*Use or disclosure of Psychotherapy Notes. Use or disclosure of psychotherapy notices includes all activities utilizing the notes, including but not limited to research activities.

Any request you may have of The Plan must be submitted in writing, including complaints. All required forms are available at Human Resources. You have the right to:

1. Request restrictions on certain uses and disclosures of your health information. The Plan is not required to agree to the restriction that you requested. Except as provided in the next paragraph, we will honor the restriction until you revoke it or we notify you.

- Effective January 1, 2022, we will comply with your restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

2. Request the Plan to communicate with you in a certain way or at a certain location. For example, you may ask to be contacted only while at work or by email.

3. Right to be notified if we (or a Business Associate) discover a breach of unsecured protected health information.

4. Inspect and receive a copy of certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

5. Change or add information to your designated records; however, The Plan may not change the "original" documents.

6. An accounting of disclosures of your protected health information made by The Plan. However, The Plan does not have to account for disclosures related to treatment, payment, health care operations, information provided to the patient, specialized government functions, and disclosures authorized by the patient.

7. Right to receive a paper copy of this Notice even if you receive this electronically.

IV. Complaints

1. If you need more information, have complaints, or feel that your privacy rights have been violated, contact us **by email at hrmail@gesa.com**

Remember, any request you may have of The Plan must be submitted in writing, including complaints, to the above address.

2. If you are not satisfied with how Human Resources handles your concern, you may submit a formal complaint to: U.S. Dept. of Health and Human Service Office for Civil Rights; 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

If you file a complaint, we will not take any action against you or change your treatment in any way.

This Notice of Privacy Practices applies to the following organizations: **Gesa Credit Union**

51 Gage Blvd.
Richland, WA 99352
www.gesa.com

Privacy Officer & Security Officer: Lynn Braswell, HR Manager/
Team Leader
Plan Sponsor: Cheryl Adamson, EVP of Legal and Administration

FAQs on HIPAA Portability and Nondiscrimination Requirements for Workers



U.S. Department of Labor
Employee Benefits Security Administration

What is the Health Insurance Portability and Accountability Act (HIPAA)?

HIPAA offers protections for workers and their families. The law provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events. HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information.

Taking Advantage of Special Enrollment Opportunities

What is Special Enrollment?

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents.

Under the second, employees, spouses, and new dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

What are some examples of events that can trigger a loss of eligibility for coverage?

Loss of eligibility for coverage may occur when:

- Divorce or legal separation results in you losing coverage under your spouse's health insurance;
- A dependent is no longer considered a "covered" dependent under a parent's plan;
- Your spouse's death leaves you without coverage under his or her plan;
- Your spouse's employment ends, as does coverage under his employer's health plan;
- Your employer reduces your work hours to the point where you are no longer covered by the health plan;
- Your plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time);
- You no longer live or work in the HMO's service area.

These should give you some idea of the types of situations that may entitle you to a special enrollment right.

How long do I have to request special enrollment?

It depends on what triggers your right to special enrollment. The employee or dependent must request enrollment within 30 days after losing eligibility for coverage or after a marriage, birth, adoption, or placement for adoption.

The employee or dependent must request enrollment within 60 days of the loss of coverage under a state CHIP or Medicaid program or the determination of eligibility for premium assistance under those programs.

After I request special enrollment, how long will I wait for coverage?

It depends on what triggers your right to special enrollment. Those taking advantage of special enrollment as a result of a birth, adoption, or placement for adoption begin coverage no later than the day of the event.

For special enrollment due to marriage or loss of eligibility for other coverage, your new coverage will begin on the first day of the first month after the plan receives the enrollment request. If the plan receives the request on January 3, for example, coverage would begin on February 1.

What coverage will I get when I take advantage of a special enrollment opportunity?

Special enrollees must be offered the same benefits that would be available if you are enrolling for the first time. Special enrollees cannot be required to pay more for the same coverage than other individuals who enrolled when first eligible for the plan.

Can my new group health plan deny me benefits because I have a preexisting condition?

While HIPAA previously provided limits on preexisting condition exclusions, new protections under the Affordable Care Act (ACA) prohibit group health plans from imposing any preexisting condition exclusion. Under this protection, a plan generally cannot limit or deny benefits relating to a health condition that was present before your enrollment date in the plan.

Where do I find out more about special enrollment in my plan?

A description of special enrollment rights should be included in the plan materials you received when initially offered the opportunity to enroll.

How will I know if I am eligible for assistance with group health plan premiums under CHIP or Medicaid?

You need to contact your state's CHIP or Medicaid program to see if your state will subsidize group health plan premiums and to determine if you are eligible for the subsidy under these programs. For information on the program in your state, call 1-877-KIDSNOW (543-7669) or visit InsureKidsNow.gov on the Web. If you are eligible for this premium assistance, you need to contact your plan administrator or employer to take advantage of the special enrollment opportunity and enroll in the group health plan.

HIPAA's Protections from Discrimination

What are HIPAA's protections from discrimination?

Under HIPAA, you and your family members cannot be denied eligibility or benefits based on certain "health factors" when enrolling in a health plan. In addition, you may not be charged more than similarly situated individuals based on any health factors. The questions and answers below define the health factors and offer some examples of what is and is not permitted under the law.

What are the health factors under HIPAA?

The health factors are:

- Health status;
- Medical conditions, including physical and mental illnesses;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability (see below); and
- Disability.

Conditions arising from acts of domestic violence as well as participation in activities like motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, and skiing are

considered "evidence of insurability." Therefore, a plan cannot use them to deny you enrollment or charge you more for coverage. (However, benefit exclusions known as "source of injury exclusions" could affect your benefits. These exclusions are discussed in more detail below.)

Can a group health plan require me to pass a physical examination before I am eligible to enroll?

No. You do not have to pass a physical exam to be eligible for enrollment. This is true for individuals who enroll when first eligible, as well as for late and special enrollees.

Can my plan require me to fill out a health care questionnaire in order to enroll?

Yes, as long as the questionnaire does not ask for genetic information (including family medical history) and the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

My group health plan required me to complete a detailed health history questionnaire and then subtracted "health points" for prior or current health conditions. To enroll in the plan, an employee had to score 70 out of 100 total points. I scored only 50 and was denied a chance to enroll. Can the plan do this?

No. In this case the plan used health information to exclude you from enrolling in the plan. This practice is discriminatory, and it is prohibited.

My group health plan booklet states that if a dependent is confined to a hospital or other medical facility at the time he is eligible to enroll in the plan, that person's eligibility is postponed until he is discharged. Is this permitted?

No. A group health plan may not delay an individual's eligibility, benefits, or effective date of coverage based on confinement to a hospital or medical facility at the time he becomes eligible. Additionally, a health plan may not increase that person's premium because he was in a hospital or medical facility.

My group health plan has a 90-day waiting period before allowing employees to enroll. If an individual is in the office on the 91st day, health coverage begins then. However, if an individual is not "actively at work" on that day, the plan states that coverage is delayed until the first day that person is actually at work. I missed work on the 91st day due to illness. Can I be excluded from coverage?

No. A group health plan generally may not deny benefits because someone is not "actively at work" on the day he would otherwise become eligible.

However, a plan may require employees to begin work before health plan coverage is effective. A plan may also require an individual to work full time (say, 250 hours per quarter or 30 hours per week) in order to be eligible for coverage.

Can my group health plan exclude or limit benefits for certain conditions or treatments?

Group health plans can exclude coverage for a specific disease or limit or exclude benefits for certain treatments or drugs, but only if the restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.).

However, compliance with this rule under HIPAA does not affect whether the plan provision or practice is permitted under other laws including the ACA such as the requirement to offer essential health benefits in the individual and small group markets.

How do you determine "similarly situated individuals"?

HIPAA states that plans may distinguish among employees only on "bona fide employment-based classifications" consistent with the employer's usual business practice. For example, part time and full time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as different groups of similarly situated individuals.

A plan may draw a distinction between employees and their dependents. Plans can also make distinctions between beneficiaries themselves if the distinction is not based on a health factor. For example, a plan can distinguish between spouses and dependent children, or between dependent children age 26 and older based on their age or student status.

I have a history of high claims. Can I be charged more than others in the plan based on my claims experience?

No. Group health plans cannot charge an individual more for coverage than a similarly situated individual based on any health factor.

However, be aware that HIPAA does allow an insurer to charge one group health plan (or employer) a higher rate than it does another. When an insurance company establishes its rates, it may underwrite all covered individuals in a specific plan based on their collective health status. The result can be that one employer health plan whose enrollees have more adverse health factors can be charged a higher premium than another for the same amount of coverage. Note that compliance with this rule under HIPAA does not affect whether the practice is permitted under the ACA including the rating requirements in the small group market.

Think of it this way: HIPAA's protections from discrimination apply within a group of similarly situated individuals, not across different groups of similarly situated individuals. For example, an employer distinguishes between full-time and part-time employees. It can charge part-time employees more for coverage, but all full-time employees must pay the same rate, regardless of health status.

Also, for insured plans, state law may govern rates for health coverage. More information is available at NAIC.org.

I am an avid skier. Can my employer's plan exclude me from enrollment because I ski?

No. Participation in activities such as skiing would be "evidence of insurability," which is a health factor. Therefore, it cannot be used to deny eligibility.

Can my health plan deny benefits for an injury based on how I got it?

It depends. A plan can deny benefits based on an injury's source, unless an injury is the result of a medical condition or an act of domestic violence.

Therefore, a plan cannot exclude coverage for self-inflicted wounds, including those resulting from attempted suicide, if they are otherwise covered by the plan and result from a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or from domestic violence. For example, a plan generally can exclude coverage for injuries in connection with an activity like bungee jumping. While the bungee jumper may have to pay for treatment for those injuries, her plan cannot exclude her from coverage for the plan's other benefits.

My group health plan says that dependents are generally eligible for coverage only until they reach age 26. However, this age restriction does not apply to disabled dependents, who seem to be covered past age 26. Does HIPAA permit a policy favoring disabled dependents?

Yes. A plan can treat an individual with an adverse health factor (such as a disability) more favorably by offering extended coverage.

Are all family members, including a spouse, covered by HIPAA?

If your group health plan permits coverage of family members ("dependents"), and if they participate in the plan, then they will have the same HIPAA protections as employees.

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) expands the HIPAA nondiscrimination provisions discussed above by generally prohibiting the use of genetic information to adjust group premiums or contributions, the collection of genetic information and requests for individuals to undergo genetic testing.

HIPAA and Wellness Programs

I've learned that my health plan will include a wellness program next year. What is a wellness program?

Wellness programs encourage employees to work out, stop smoking or generally adopt healthier lifestyles by offering some type of financial or other incentive. If a wellness program is part of a group health plan, it must comply with rules created by HIPAA and the ACA that prevent the employee from being impermissibly discriminated against based on a health factor.

There are two types of wellness programs - participatory and health-contingent. A participatory wellness program is one that offers a reward simply for participating in the program. For example, the program reimburses employees for all or part of the cost for membership in a fitness center. Participatory wellness programs are allowed under the nondiscrimination rules as long as they are available to all similarly situated individuals.

A health-contingent wellness program is one that rewards an employee for satisfying a standard related to a health factor. If the standard is an activity-only one, you need to perform or complete an activity, like walking or other exercise, to get the reward. If the standard is outcome-based, you must achieve a specific health outcome, like a certain result on a health screening, to get the reward. Health-contingent wellness programs must meet certain requirements.

I belong to a group health plan that rewards individuals who volunteer to be tested for early detection of health problems, such as high cholesterol. Can a plan do this?

Yes, as long as the program is available to all similarly situated individuals. If the health plan offers a reward based on participation in the program and not on test results, the program is considered a participatory wellness program and the plan does not have to comply with the additional requirements applicable to health-contingent wellness programs. For instance, a health plan can offer a premium discount for those who voluntarily test for cholesterol, as long as the discount is available to everyone who takes the test and not just those who get a certain result. If the discount was based on individuals having certain results, additional requirements discussed below would apply.

My plan's wellness program offers a lower deductible to those who participate in a specific walking program. How can I tell if this is permissible?

Because the reward (the lower deductible) is available to all who participate in a walking program, this is an activity-only health-contingent program. The program will be permissible if:

- Individuals have a chance to qualify for the reward at least once per year;
- The total reward for all of the plan's health-contingent wellness programs is not more than 30% of the cost of employee-only coverage in the plan. If dependents can participate, the reward cannot be more than 30% of the cost of the coverage in which an employee and dependents are enrolled. For wellness programs designed to prevent or

reduce tobacco use the allowable percentage is higher – the reward for those programs cannot be more than 50% of the cost of coverage;

- The walking program is reasonably designed to promote health or prevent disease;
- A reasonable alternative standard (or a waiver of the walking requirement) is offered to those for whom it is unreasonably difficult because of a medical condition, or medically inadvisable, to participate in the walking program; and
- The plan discloses the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program.

I would like to participate in my plan's wellness program. Under the program, to get a discount on my premiums, my body mass index (BMI) must be 26 or lower. Is there any way for me to get the premium discount if my BMI is higher than 26?

Yes. The reward is provided to those who achieve a specific health outcome (BMI of 26 or lower), so this is an outcome-based health-contingent wellness program. If your BMI is above 26, the plan must provide you with a reasonable alternative standard to qualify for the reward. The reasonable alternative standard could be activity-based such as completion of an educational program, participation in a diet program, or following the recommendations of your personal physician; it could also be another outcome-based standard, such as a one-point reduction in your BMI over a set period of time. If it is unreasonably difficult because of a medical condition, or medically inadvisable, for you to complete the alternative, the plan must work with you to find a second alternative based on your physician's recommendations.

In addition, as with an activity-only program, you must be given the chance to qualify for the reward at least once per year; the total reward for the plan's health-contingent wellness programs cannot be more than 30% (or 50% for tobacco-related programs) of the cost of employee-only coverage (or the cost of the coverage enrolled in if dependents can participate); and the plan must disclose the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program. This notice must also be included in any disclosure that you did not satisfy the initial standard.

Can a plan charge a lower premium for nonsmokers than it does for smokers?

The plan is offering a reward based on an individual's ability to stop smoking so this is an outcome-based program. For this type of wellness program to be permissible:

- Individuals must have a chance to qualify for the nonsmoker's discount at least once a year;
- The difference in premiums between nonsmokers and smokers cannot be more than 50% of the cost of employee-only coverage (or 50% of the cost of coverage if dependents can participate);
- The program must be reasonably designed to promote health and prevent disease;
- There is a reasonable alternative standard to those who do not meet the otherwise applicable standard. For example, the reasonable alternative standard could include discounts in return for attending educational classes or for trying a nicotine patch; and
- Plan materials describing the premium discount (and any disclosure that an individual did not satisfy the standard) describe the availability of a reasonable alternative standard to qualify for the lower premium.

Coordination with Other Laws

Can states modify HIPAA's requirements?

State laws may complement HIPAA by allowing more protections than the Federal law. For example, states may increase the number of days parents have to enroll newborns, adopted children, and children placed for adoption or require additional circumstances that entitle you to special enrollment periods beyond those in the Federal law. However, these state laws only apply if your plan provides benefits through an insurance company or HMO (an insured plan). To determine if your plan offers insured coverage, consult your Summary Plan Description (SPD) or contact your plan administrator. You also can visit your state insurance commissioner's office or the National Association of Insurance Commissioners' [Website](#) (select your state) for more information.

How can I use HIPAA in conjunction with COBRA to extend my health coverage?

COBRA is a law that can help if you lose your job or if your hours are reduced to the point where the employer no longer provides you with health coverage. COBRA can provide a temporary extension of your health coverage – as long as you and your family members, if eligible, belonged to the previous employer's health plan and generally the employer had 20 or more employees. Usually, you pay the entire cost of coverage (both your share and the employer's, plus a 2 percent administrative fee). As long as the prior plan exists, COBRA coverage lasts up to 18 months for most people, although it can continue as long as 36 months in some cases.

If you enroll in COBRA, HIPAA provides you with the opportunity to request special enrollment in a different group health plan if you have a special enrollment event, such as marriage, the birth of a child, or if you exhaust your continuation coverage. To exhaust COBRA, you must receive the maximum period of continuation coverage available (usually 18 months for job loss) without early termination. If you choose to terminate your COBRA early, or fail to pay your COBRA premiums, you generally will not be entitled to special enroll in other group health coverage.

Do I have other special enrollment rights?

In addition to the special enrollment rights in a group health plan under HIPAA (described above), there are also special enrollment rights under the ACA for individual coverage including through the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance and other options (such as Medicare and CHIP coverage). Losing your job-based coverage, marriage, birth, and adoption are a few of the special enrollment events that may allow you to purchase Marketplace or other coverage outside of the regular enrollment period.

To qualify for special enrollment, you must select a plan either within 60 days before losing your job-based coverage or within 60 days after losing your job-based coverage.

You can apply for Marketplace coverage online or get more information at [HealthCare.gov](https://www.healthcare.gov) or by calling 1-800-318-2596 (TTY users should call 1-855-889-4325). When you fill out a

Marketplace application, you also can find out if you and your family qualify for free or low-cost coverage from Medicaid and/or the Children's Health Insurance Program (CHIP).

Where can I get more information on my rights under HIPAA?

The Employee Benefits Security Administration offers more information on HIPAA and other laws mentioned above. Visit the Employee Benefits Security Administration's **Website** to view the following publications. To order copies or to request assistance from a benefits advisor, **contact EBSA** electronically or call toll free 1-866-444-3272.

- **Retirement and Health Care Coverage...Questions and Answers for Dislocated Workers**
- **An Employee's Guide to Health Benefits Under COBRA**
- **Top 10 Ways to Make Your Health Benefits Work for You**
- **Life Changes Require Health Choices...Know Your Benefit Options**

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Coverage for: Individual or Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-722-1471 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$2,000 Individual / \$4,000 Family. Out-of-network: \$4,000 Individual / \$8,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Does not apply to <u>Preventive care</u> , <u>copayments</u> , <u>prescription drugs</u> and services listed below as "No charge"	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. For pharmacy: \$150 Individual/\$300 Family. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: \$7,000 Individual / \$14,000 Family, Out-of-network: Not Applicable	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>prior authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> (<u>deductible</u> does not apply)	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> (<u>deductible</u> does not apply)	50% <u>coinsurance</u>	<u>Prior authorization</u> required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.premera.com/documents052147_2022.pdf	Generic drugs	\$15 <u>copay</u> /prescription (retail), \$30 <u>copay</u> /prescription (mail)	\$15 <u>copay</u> /prescription + 40% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Pharmacy <u>deductible</u> does not apply. <u>Prior authorization</u> required for some drugs.
	Preferred brand drugs	\$35 <u>copay</u> /prescription (retail), \$70 <u>copay</u> /prescription (mail)	\$35 <u>copay</u> /prescription + 40% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Pharmacy <u>deductible</u> applies. <u>Prior authorization</u> required for some drugs.
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription	\$50 <u>copay</u> /prescription + 40% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Pharmacy <u>deductible</u> applies. <u>Prior authorization</u> required for some drugs.
	<u>Specialty drugs</u>	\$75 <u>copay</u> /prescription	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Pharmacy <u>deductible</u> applies. <u>Prior authorization</u> required for some drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required for some services. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u> + 20% <u>coinsurance</u>	\$200 <u>copay/visit</u> + 20% <u>coinsurance</u>	Emergency room <u>copay</u> waived if admitted to hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	Hospital-based: \$200 <u>copay/visit</u> + 20% <u>coinsurance</u> Freestanding center: \$40 <u>copay/visit</u>	Hospital-based: \$200 <u>copay/visit</u> + 20% <u>coinsurance</u> Freestanding center: 50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$30 <u>copay/visit</u> Facility: 20% <u>coinsurance</u> (<u>deductible</u> does not apply)	50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 130 visits per calendar year
	<u>Rehabilitation services</u>	Outpatient: \$40 <u>copay</u> /visit Inpatient: 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 15 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	<u>Habilitation services</u>	Outpatient: \$40 <u>copay</u> /visit Inpatient: 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 15 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 120 days per calendar year. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
	If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	None
Children's dental check-up		Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care	<ul style="list-style-type: none">• Private-duty nursing• Routine eye care (Adult)• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture• Chiropractic care or other spinal manipulations	<ul style="list-style-type: none">• Foot care	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: your [plan](#) at 1-800-722-1471 or TTY 1-800-842-5357, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-722-1471.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-722-1471.

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,000
- Specialist copay \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,170

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,000
- Specialist copay \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$200
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,540

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- Specialist copay \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$1,800
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,420

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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/online-services/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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

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

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

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

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

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

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

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

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

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

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

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

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

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

Gesa Credit Union : Your Future HSA Emb NGF

Coverage for: Individual or Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-722-1471 (TTY: 1-800-842-5357) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$5,000 Individual / \$10,000 Family. Out-of-network: \$10,000 Individual / \$20,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Does not apply to <u>Preventive care</u> and services listed below as "No charge"	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network: \$5,000 Individual / \$10,000 Family, Out-of-network: Not Applicable	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>prior authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-722-1471 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Specialist</u> visit	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Deductible</u> applies.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.premera.com/documents/052148_2022.pdf	Generic drugs	0% <u>coinsurance</u>	0% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). <u>Prior authorization</u> required for some drugs. <u>Deductible</u> applies.
	Preferred brand drugs	0% <u>coinsurance</u>	0% <u>coinsurance</u> (retail), not covered (mail)	
	Non-preferred brand drugs	0% <u>coinsurance</u>	0% <u>coinsurance</u> (retail), not covered (mail)	
	<u>Specialty drugs</u>	0% <u>coinsurance</u>	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. <u>Prior authorization</u> required for some drugs. <u>Deductible</u> applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required for some services. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
	Physician/surgeon fees	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Urgent care</u>	0% <u>coinsurance</u>	Hospital-based: 0% <u>coinsurance</u> Freestanding center: 50% <u>coinsurance</u>	<u>Deductible</u> applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay. <u>Deductible</u> applies.
	Physician/surgeon fees	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Deductible</u> applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Deductible</u> applies.
	Inpatient services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay. <u>Deductible</u> applies.
If you are pregnant	Office visits	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). <u>Deductible</u> applies.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). <u>Deductible</u> applies.
	Childbirth/delivery facility services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). <u>Deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 130 visits per calendar year. <u>Deductible</u> applies.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 15 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay. <u>Deductible</u> applies.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 15 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay. <u>Deductible</u> applies.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 days per calendar year. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay. <u>Deductible</u> applies.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Prior authorization</u> required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
	<u>Hospice services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise. <u>Deductible</u> applies.
	If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	None
Children's dental check-up		Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care	<ul style="list-style-type: none">• Private-duty nursing• Routine eye care (Adult)• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture• Chiropractic care or other spinal manipulations	<ul style="list-style-type: none">• Foot care	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: your [plan](#) at 1-800-722-1471 or TTY 1-800-842-5357, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-722-1471.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-722-1471.

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$5,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,020

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$5,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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/online-services/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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ 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)።

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

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

ਪਿਆਰਨ ਦਿਉ: 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).

ໂປດຊາຍ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

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

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

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

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

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

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

Summary of Contract Changes for Washington Large Groups (Insured and Self-Funded)

Premera Blue Cross has made changes to **medical plans** that are scheduled to take effect at your upcoming renewal. This summary lists the major changes and shows which changes are mandated by federal or state law or regulation. Not all the changes listed may apply to your plan or plans.

For Insured plans: Subject to change, pending OIC approval.

MEDICAL BOOKLETS

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Throughout the booklet(s)	General updates including punctuation, formatting, spelling and updating references to websites.	Standard updates
<i>All NGF Medical Plans</i>	<i>All Funding Types</i>	Summary Of Your Costs under Summary Table	Indicated non-participating providers can bill for amounts over the allowed amount emergency services, covered air ambulance services or as prohibited by law.	Clarifying language required per Balance Billing Protection Act (BBPA)
<i>All NGF Medical Plans (If applicable)</i>	<i>All Funding Types</i>	Summary Of Your Costs – Cellular Immunotherapy And Gene Therapy	For benefits with cost-shares listed as “Covered as any other service” there is a note to clarify additional costs for other services.	Clarification – due to OIC objection to better explain “covered as any other service”
<i>All NGF Medical Plans (If applicable)</i>	<i>All Funding Types</i>	Summary Of Your Costs – Clinical Trials	For benefits with cost-shares listed as “Covered as any other service” there is a note to clarify additional costs for other services.	Clarification – due to OIC objection to better explain “covered as any other service”
<i>All Medical Plans</i>	<i>All Funding Types</i>	Summary Of Your Costs – Dental Care	Revising “Dental Care” header to “Dental Injury and Facility Anesthesia”	This better describes how dental is covered under the medical plan.

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Summary Of Your Costs – Gender Affirming Care (Previously Transgender Services)	Updated all references of “transgender” to “gender affirming” and revised the “Transgender Services” header to “Gender Affirming Care”.	This better describes more accurately the type of care offered. Aligns with the healthcare industry’s terminology.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Summary Of Your Costs – Medical Transportation – State Restricted Care	Benefit added for Medical Transportation – State Restricted Care. This is a travel support benefit utilized for abortion and gender affirming care.	New benefit
<i>All Medical Plans</i>	<i>Insured and OptiFlex (ASC must opt in)</i>	Summary Of Your Costs – Prescription Drug	Insulin cap mandate updated from a \$100 cap for a 30-day supply to a \$35 cap for a 30-day supply.	Washington State Legislature enacted SB 5546 capping a covered insulin drug at an amount not to exceed \$35 for a 30-day supply.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Summary Of Your Costs – Prescription Drug	Updating the term birth control to contraceptive or contraceptives.	Language clarification to better align with state requirements.
<i>All Medical Plans</i>	<i>All Funding Types</i>	How Providers Affect your Costs – In-Network Providers	Further describes how In-Network Providers are covered.	Clarifying to be more specific on In-Network Providers.
<i>All NGF Medical Plans</i>	<i>All Funding Types</i>	How Providers Affect your Costs –Continuity Of Care	We have updated & rewritten some language to the Continuity Of Care section.	Clarification & revision due to OIC objection, new Federal guidelines & due to BBPA
<i>All Medical Plans</i>	<i>All Funding Types</i>	How Providers Affect your Costs – Non-Participating Providers, Balance Billing Protection and Benefits For	Revisions and language changes made to the term Out-Of-Network to Non-Participating, changed Surprise Billing Protection to Balance Billing Protection and added Or Non-Contracted to Benefits For Out-Of-Network Providers	Clarifying language required per BBPA

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
		Out-Of-Network Or Non-Contracted Providers		
<i>All Medical Plans</i>	<i>All Funding Types</i>	How Providers Affect your Costs – Contracted Health Care Benefit Managers	Updated the website from www.premera.com/visitors/companies-we-work-with to the following: www.premera.com/visitors/partners-vendors	Incorrect website listed.
<i>All Medical Plans</i>	<i>All Funding Types</i>	How Providers Affect your Costs – Allowed Amount	Revisions and language changes made to the Allowed Amount section. Updated Non-Emergency Services and Emergency Care	Clarifying language required per BBPA
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services - Dental Care	Revising “Dental Care” header to “Dental Injury and Facility Anesthesia”. We also added a directional to explain other cost-sharing amounts for the initial benefit can depend on where the service is received.	This better describes how dental is covered under the medical plan. There was also an OIC objection to explain other cost-sharing amounts.
<i>All NGF Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Diagnostic X-Ray, Lab, And Imaging	Removed “ <i>The same test, like a colonoscopy, can be either Preventive or Diagnostic. If the test was ordered to evaluate a sign, symptom or health concern, it is Diagnostic</i> ” and replaced with “ <i>For more information about what services are covered as preventive see Preventive Care</i> ”	Clarification & revision due to federal recommendation of the U.S. Preventive Services Task Force (USPSTF)
<i>All NGF Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Emergency Room	Revised & additional language added stating, “ <i>Services and exams used for stabilizing an emergency medical condition, including mental health or substance use disorder</i> ” Revised “ <i>Medically necessary detoxification</i> ” to “ <i>Emergency detoxification</i> ”.	Clarification due to OIC objection.

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Gender Affirming Care	Updated all references of “transgender” to “gender affirming” and revised the “Transgender Services” benefit header to “Gender Affirming Care”.	This better describes more accurately the type of care offered.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Home Health Care	Home Health care can be substitute for Medically Necessary inpatient hospitalization as long as services can be provided at equal or lesser cost and is the most appropriate and cost-effective setting.	Language clarification to better explain benefit.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Hospital	Revised and additional language added stating, “You will not be balanced billed for certain services provided by a non-participating provider”.	Clarification due to OIC objection.
<i>All NGF Medical Plans</i>	<i>All Funding Types</i>	Covered Services - Maternity Care	Removed “for all female members” to avoid limiting coverage due to gender.	Clarification due to OIC objection regarding coverage limitations based on an individual's sex assigned at birth, gender identity or recorded gender.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services - Maternity	Revised and additional language stating, “This benefit covers medically necessary donor human milk obtained from a milk bank for inpatient use when ordered by licensed healthcare provider”.	Washington State Legislature enacted SB 5702 that requires health plans to provide coverage for donor human milk for inpatient use when medically necessary.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services - Maternity	Added the following language as a cross reference: For members residing in states where laws prohibit access to abortion services, travel to a provider in another state may be covered. Please see Medical Transportation – State-Restricted Care for details.	New benefit cross reference.

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Medical Foods	Revised language in benefit to specifically state medically necessary elemental formula is covered.	Language clarification to better explain benefit.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Medical Transportation	The term Travel Claim Form was changed to Claim Reimbursement Form.	Clarification based on the claim forms found on Premera.com.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Medical Transportation – State Restricted Care	Benefit added for Medical Transportation – State Restricted Care. This is a travel support benefit utilized for abortion and gender affirming care.	New benefit
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Mental Health Care	Revised and added additional providers who can furnish mental health services.	Updating provider credentials for mental health services.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Orthognathic Surgery (Jaw Augmentation Or Reduction)	Revised language to indicate there is no annual or lifetime maximum for orthognathic surgery due to a congenital anomaly.	Clarification to align with our medical payment policy.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Premera-Designated Centers of Excellence	Removed all provider names from the Premera-Designated Centers of Excellence benefit.	We are removing provider names as new providers can be added without making continuous updates.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Prescription Drug	Updating the term birth control to contraceptive or contraceptives.	Language clarification to better align with state requirements.
<i>All Medical Plans (GF if applicable)</i>	<i>All Funding Types</i>	Covered Services – Preventive Care	Revised Screening Tests, Pregnant Women’s Care, Colon Cancer Screening, updated the term Birth Control and added Pre-exposure (PrEP).	Clarifications and required federal regulations.

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Rehabilitation Therapy	We have added a statement indicating “Chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases are covered as any other medical condition and do not accrue to rehabilitation therapy limits”.	Federal mandate, to comply with HHS’ Notice of Benefit and Payment Parameters (NBPP).
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Substance Use Disorder	Updated the term chemical dependency to substance use disorder condition. Additionally, added a statement stating acupuncture services when provided for substance use disorder conditions do not apply to the acupuncture benefit visit limit.	Updated the term to be more consistent with the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services - Surgery	Added the following language as a cross reference: For members residing in states where laws prohibit access to medically necessary gender affirming care, travel to a provider in another state may be covered. Please see Medical Transportation – State-Restricted Care for details.	New benefit cross reference.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Temporomandibular Joint Disorders (TMJ) Care	Added in language to describe what is required for the TMJ benefit to be “medical services”.	Clarification due to OIC objection.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Covered Services – Virtual Care	We have incorporated a definition of audio only.	Clarification to align with state requirements.

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Exceptions to Prior Authorization for Out-of-Network Providers	The following sentence was removed, <i>"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."</i>	Removed due to BBPA
<i>All Medical Plans</i>	<i>All Funding Types</i>	Exclusions - Illegal Acts, Illegal Services, and Terrorism	The language for this exclusion was expanded with the addition, <i>"as well as any service that is illegal under state or federal law"</i> . Also, <i>"illegal services"</i> was added to exclusion title.	Clarification per the direction of Premera legal department
<i>All Medical Plans</i>	<i>All Funding Types</i>	Exclusions - Orthognathic Surgery	The language for this exclusion was rewritten.	Clarification to align with our medical payment policy.
<i>All Medical Plans</i>	<i>Insured Plans</i>	What If I Have Other Coverage? – COB's Effect On Benefits	Revised how the secondary plan pays so members clearly understand their benefits.	Clarification due to OIC objection.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Who Is Eligible For Coverage?	Removed the statement <i>"Please note that you do not have to be a citizen of or live in the United States if you are otherwise eligible for coverage"</i> .	Clarification per the direction of Premera legal department
<i>All Medical Plans</i>	<i>All Funding Types</i>	Who Is Eligible For Coverage? - Dependent Eligibility	Removed the term <i>"A legally placed ward"</i> with the term <i>"A legally placed dependent"</i> .	The term <i>"ward"</i> is an outdated term.

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Complaints and Appeals	Clarified and updated Complaints and Appeals section language.	Clarification – language updated to clarify Appeals processed due to OIC objection, aligned appeals language across all lines of business & reformatting style.
<i>All Medical Plans</i>	<i>Insured Plans</i>	Additional Information About Your Coverage	Added language to explain how to replace your ID card.	Clarification due to OIC objection.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Definitions	The definitions for Chemical Dependency has been revised to Substance Use Disorder Conditions.	Aligning with state requirement.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Definitions	Added the term Donor Human Milk and Milk Bank	Washington State Legislature enacted SB 5702 that requires health plans to provide coverage for donor human milk for inpatient use when medically necessary.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Definitions	The term Medical Emergency was revised to Emergency Medical Condition. Additionally, all references to medical emergency in the booklets were replaced with emergency medical condition.	Aligning with state requirement.
<i>All Medical Plans</i>	<i>All Funding Types</i>	Definitions	The term Emergency Care was updated to Emergency Services and rewritten. Additionally, all references to emergency care were updated throughout the booklet to emergency services.	Clarification due to OIC objection.

Impacted Plan	Funding Type(s) Impacted	Booklet Sections Affected	Description of Change	Reason for Change
<i>All Medical Plans</i>	<i>All Funding Types</i>	Definitions	Added the term Non-Participating Provider	Clarifying language required per BBPA
<i>All Medical Plans</i>	<i>All Funding Types</i>	Definitions	Updated the definition of Virtual Care adding in originating site.	Clarification due to OIC objection.

EMPLOYER AGREEMENT (Insured)

Agreement Sections Affected	Description of Change	Reason for Change
<i>Compliance With Law (Employer Agreement)</i>	Under the section for Association/MEWA we added the following to the last paragraph of the Compliance With Law section: "laws and regulations governing the treatment and benefits of members covered by Medicare, and The No Surprises Act, enacted as part of the Consolidated Appropriations Act, 2021."	Update per No Surprises Act and Consolidated Appropriations Act.
<i>Compliance With Law (Employer Agreement)</i>	We have added language to the end of the Compliance With Law section to address Transparency in Coverage rules.	Updated for Transparency in Coverage rules
<i>Records Maintenance (Employer Agreement)</i>	Removing the following: "and shall be maintained for a term of at least 11 years".	Clarification per the direction of Premera legal department
<i>Insured Funding Arrangement (Exhibit A) Section I Definitions</i>	The Customization Fee definition has been updated to change the customization fee from \$2,000 to \$5,000.	Underwriting request
<i>Insured Funding Arrangement (Exhibit A) Section III.B. Late Payments</i>	The term "at its discretion" has been removed.	Clarification due to OIC objection.

ASC/OptiFlex Agreements

<i>Agreement Sections Affected</i>	Description of Change	Reason for Change
<i>Section 2. Duties And Responsibilities Of The Plan Sponsor 2.6 Compliance With The Law, Section 3.1 Duties and Responsibilities of the Claims Administrator and in Section 11.2 Proprietary Information</i>	We have added language to address Transparency in Coverage rules.	Updated for Transparency in Coverage rules
<i>Section 5 Fees of the Claims Administrator (ASC Agreement)</i>	Customization fee was changed from \$2,000 to \$5,000.	Underwriting request
<i>Attachment D Funding Rates – Kinwell Overlay (only showing on ASC Agreements)</i>	The Premera Kinwell overlay program provides access for members who receive covered services from a Kinwell provider to have lower cost shares, schedule same or next day appointments, have access to a dedicated concierge line or care advocate resource for appointment scheduling and benefit questions.	New program option
<i>Attachment D Funding Rates - Extended Payment Integrity Services</i>	Increasing all fees to 35% and updating the Subrogation language.	Underwriting request
<i>Attachment for CareCompass360</i>	Premera Pulse Concierge and Premera Pulse have been discontinued for 2023	Business decision due to low utilization
<i>Attachment for Extended Payment Integrity Services</i>	Attachment was re-titled from “Extended Post Payment Recovery Services” and changed to “Extended Payment Integrity Services”. Language within this attachment was revised.	Revision due to restructure of service provided
<i>Attachment for Premera-Designated Centers Of Excellence</i>	We have removed the listed Centers of Excellence providers.	We are removing provider names as new providers can be added without making continuous updates.

STATE-MANDATED BENEFIT OFFERINGS FOR INSURED GROUPS

At each renewal, all health carriers must present the state-mandated chiropractic coverage offering to insured groups that do not include them in their plans currently. **If your plan's benefits don't match the descriptions shown in column 2, you don't have to do anything. But, if your current coverage does match the descriptions shown in column 2 below, then please tell us if you want to upgrade your current benefit.** If you want to upgrade, please contact your Account Manager. If you do not want to upgrade, please check the "No" box and add your initials. If you would like more information about this offering, please contact your Premera Blue Cross representative.

Benefit	If Your Current Coverage Is:	You Can Upgrade Coverage To:	No	Initials
<i>Chiropractic Care</i>	Combined with osteopathic manipulations up to a set number of visits per year	Covered on the same basis as other physician care (no visit limit)		

OTHER PLAN CHANGES

- Please tell us about eligibility changes you want to make to your plan at this year's renewal.
- If you have an IRS Section 125 cafeteria plan, please make sure your book explains any midyear family status changes that trigger enrollment or plan changes.
- Please note any change in the Group's legal name or address, or if you want to add or drop affiliates or subsidiaries from your plan.



**Gesa
Credit
Union**

Your Choice™ Split Copay*

4000063

INTRODUCTION

*This booklet is for members of the Gesa Credit Union medical plan. This plan is self-funded by Gesa Credit Union, which means that Gesa Credit Union is financially responsible for the payment of plan benefits. Gesa Credit Union (“the Group”) has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

Gesa Credit Union has contracted with Premiera Blue Cross, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. Gesa Credit Union has delegated to Premiera 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. Premiera Blue Cross does not insure the benefits of this plan.

In this booklet Premiera 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: Gesa Credit Union

Effective Date: January 1, 2022

Group Number: 4000063

Plan: Your Choice Split Copay (Non-Grandfathered)

Certificate Form Number: 40000630122YCS

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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំណប់ឡើងវិញ។ 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。

ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNA: 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).

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

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

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

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

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

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

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

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

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:

- **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, copays, coinsurance, and the out-of-pocket maximum.
- **Covered Services** – details about what's covered
- **Prior Authorization** – Describes the plan's prior authorization and emergency admission notification requirements.
- **Exclusions** — services that are either limited or not covered under this plan
- **Who Is Eligible For Coverage?** – eligibility requirements for this plan
- **How Do I File A Claim?** — step-by-step instructions for claims submissions
- **Complaints And Appeals** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: “You” and “your” refer to members under this plan. “We,” “us” and “our” refer to Premera Blue Cross.

FOR MORE INFORMATION

You'll find our contact information on the back cover of this booklet. Please call or write Customer Service for help with:

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

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

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

You can use our Web site to:

- 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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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***.
- 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 **copays**. These are set dollar amounts you pay at the time you get some services. If the amount billed is less than the copay, you pay only the amount billed. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary. The deductible does not apply to most services that require a copay. Any exceptions are shown in the table.

This plan has a different copay for office visits with specialists than with non-specialists. To find out which providers get which copays, see ***How Providers Affect Your Costs***.

	In-Network Providers
Non-specialist professional visit copay	\$30
Specialist professional visit copay	\$40

- 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 each deductible separately with each claim that applies to it.

	In-Network Providers	Out-of-Network Providers
Individual deductible	\$2,000	\$4,000
Family deductible (not shown in the summary table)	\$4,000	\$8,000

- **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.

	In-Network Providers	Out-of-Network Providers
Coinsurance	20%	50%

- 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. See ***Important Plan Information*** for details.

	In-Network Providers	Out-of-Network Providers
Individual out-of-pocket maximum	\$7,000	None
Family out-of-pocket maximum	\$14,000	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 .

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture <ul style="list-style-type: none"> Office and Clinic Visits calendar year visit limit: 12 visits Inpatient or other outpatient professional care 	\$30 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Allergy Testing And Treatment	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Ambulance	\$2,000 deductible, then 20% coinsurance	\$2,000 deductible, then 20% coinsurance
Blood Products and Services	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% 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	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Clinical Trials Covers routine patient care during the trial	Covered as any other service	Covered as any other service
Dental Care <ul style="list-style-type: none"> Dental Anesthesia (up to age 19 when medically necessary) <ul style="list-style-type: none"> Inpatient facility care Outpatient surgery center Anesthesiologist Dental Injury <ul style="list-style-type: none"> Exams to determine treatment needed Treatment 	\$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance \$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Diagnostic X-Ray, Lab And Imaging for medical conditions or symptoms Tests, lab, imaging and scans Dialysis For permanent kidney failure. See the Dialysis benefit for details. <ul style="list-style-type: none"> During Medicare's waiting period After Medicare's waiting period 	20% coinsurance, deductible waived \$2,000 deductible, then 20% coinsurance No charge	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance No cost-shares

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. The copay is waived if you are admitted as an inpatient through the emergency room. The copay is waived if you are transferred and admitted to a different hospital directly from the emergency room. Professional services 	<p>\$200 copay per visit, then \$2,000 deductible, then 20% coinsurance</p> <p>\$2,000 deductible, then 20% coinsurance</p>	<p>\$200 copay per visit, then \$2,000 deductible, then 20% coinsurance</p> <p>\$2,000 deductible, then 20% coinsurance</p>
<p>Foot Care such as trimming nails or corns, when medically necessary due to a medical condition</p> <ul style="list-style-type: none"> In an office or clinic All other settings 	<p>\$30 or \$40 copay per visit, deductible waived</p> <p>\$2,000 deductible, then 20% coinsurance</p>	<p>\$4,000 deductible, then 50% coinsurance</p> <p>\$4,000 deductible, then 50% coinsurance</p>
<p>Home Health Care calendar year visit limit: 130 visits</p> <ul style="list-style-type: none"> Home visits Prescription drugs billed by the home health agency 	<p>\$2,000 deductible, then 20% coinsurance</p>	<p>\$4,000 deductible, then 50% coinsurance</p>
<p>Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies</p> <ul style="list-style-type: none"> Sales tax for covered items Foot orthotics and therapeutic shoes; calendar year limit: \$300 except diabetes-related Medical vision hardware 	<p>\$2,000 deductible, then 20% coinsurance</p>	<p>\$4,000 deductible, then 50% coinsurance</p>
<p>Hospice Care Lifetime limit for terminal illness: 6 months Lifetime limit for non-terminal illness: none Inpatient stay limit: 10 days Home visits: Unlimited Respite care: 240 hours</p> <ul style="list-style-type: none"> Inpatient facility care Home and respite care 	<p>\$2,000 deductible, then 20% coinsurance</p> <p>\$2,000 deductible, then 20% coinsurance</p>	<p>\$4,000 deductible, then 50% coinsurance</p> <p>\$4,000 deductible, then 50% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<ul style="list-style-type: none"> • Prescription drugs billed by the hospice 	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
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 	\$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Infusion Therapy	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Mastectomy and Breast Reconstruction <ul style="list-style-type: none"> • Office and clinic visits • Surgery and other professional services • Inpatient facility care 	\$30 or \$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% 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 	\$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Medical Foods includes phenylketonuria (PKU)	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Medical Transportation Travel and lodging are covered up to the IRS limitations. Prior approval required. <p>For transplants: limit per transplant: \$7,500</p> <p>For cellular immunotherapy and gene therapy: \$7,500 per episode of care</p> Special criteria are required for travel benefits to be provided. Please see the benefit for coverage details.	\$2,000 deductible, then 0% coinsurance No charge	\$2,000 deductible, then 0% coinsurance No charge

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Mental Health Care <ul style="list-style-type: none"> Office and clinic visits Other professional services Inpatient and residential facility care Outpatient facility care 	\$30 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance 20% coinsurance, deductible waived	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Neurodevelopmental Therapy (Habilitation) See the Mental Health Care benefit for therapies for mental conditions such as autism. <ul style="list-style-type: none"> Outpatient care calendar year visit limit: 15 visits <ul style="list-style-type: none"> Office and clinic visits Other outpatient services Inpatient care calendar year day limit: 30 days 	\$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Newborn Care <ul style="list-style-type: none"> Inpatient care Office and clinic visits Other outpatient services 	\$2,000 deductible, then 20% coinsurance \$30 or \$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Orthognathic Surgery (Jaw Augmentation or Reduction) lifetime limit: \$5,000, for congenital anomalies the benefit limit maximum does not apply. <ul style="list-style-type: none"> Office and clinic visits Surgery and other professional care Outpatient surgery facility care Inpatient hospital care 	\$30 or \$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Prescription Drug In no case will you pay more than the cost of the drug or supply.</p> <p>Prescription Drug Deductible Separate from medical deductible</p> <ul style="list-style-type: none"> • Generic drugs • Individual deductible for brand-name and specialty drugs • Family deductible for brand-name and specialty drugs <p style="text-align: center;">Covered Drugs</p> <ul style="list-style-type: none"> • Generic drugs • Preferred brand name drugs • Non-preferred brand name drugs <ul style="list-style-type: none"> • Generic drugs • Preferred brand name drugs • Non-preferred brand name drugs <p><i>*Your cost-shares for covered prescription insulin drugs will not exceed \$100 per 30-day supply of the drug. The deductible does not apply. Cost-shares for covered prescription insulin drugs apply toward the deductible.</i></p> <p>Specialty Drugs (per prescription or refill).</p> <p style="text-align: center;">Exceptions</p> <ul style="list-style-type: none"> • Needles and syringes purchased with diabetic drugs • Certain prescription drugs and generic over-the-counter drugs to break a nicotine habit • Drugs on the Affordable Care Act's preventive drug list • Oral chemotherapy drugs • Female birth control drugs, devices and supplies (prescription and over-the-counter). Includes emergency birth control. • Male birth control devices and supplies (prescription and over-the-counter). 	<p style="text-align: center;">In-Network Pharmacy</p> <p>Waived</p> <p>\$150</p> <p>\$300</p> <p style="text-align: center;">In-Network Retail Pharmacy</p> <p>\$15 copay</p> <p>\$35 copay</p> <p>\$50 copay</p> <p style="text-align: center;">In-Network Mail-Order Pharmacy</p> <p>\$30 copay</p> <p>\$70 copay</p> <p>\$50 copay</p> <p style="text-align: center;">In-Network Pharmacy</p> <p>\$75 copay</p> <p style="text-align: center;">In-Network Retail or In-Network Mail Order Pharmacy</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 style="text-align: center;">Out-Of-Network Pharmacy</p> <p>Waived</p> <p>Shared with in-network</p> <p>Shared with in-network</p> <p style="text-align: center;">Out-Of-Network Retail Pharmacy</p> <p>\$15 copay plus 40% coinsurance</p> <p>\$35 copay plus 40% coinsurance</p> <p>\$50 copay plus 40% coinsurance</p> <p style="text-align: center;">Out-Of-Network Mail-Order Pharmacy</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p style="text-align: center;">Out-Of-Network Pharmacy</p> <p>Not covered</p> <p style="text-align: center;">Out-Of-Network Retail Pharmacy</p> <p>No cost-shares</p> <p>Same as out-of-network retail</p> <p>Same as out-of-network retail</p> <p>No cost-shares</p> <p>Same as out-of-network retail</p> <p>Same as out-of-network retail</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<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 Fall prevention for members 65 and older Immunizations in the doctor's office Flu shots and other seasonal immunizations at a pharmacy or mass immunizer location Travel immunizations at a travel clinic or county health department Health education and training (outpatient) Nicotine habit-breaking programs Nutritional counseling and therapy Pregnant women's care (includes breast-feeding support and post-partum depression screening) Screening tests (includes prostate and cervical cancer screening) Screening mammograms Colon cancer screening Male and female birth control and sterilization. (Vasectomy covered as preventive only if done in a doctor's office under local anesthetic) 	<p>In-Network Providers</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>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Out-of-Network Providers</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>No cost-shares</p> <p>No cost-shares</p> <p>Not covered</p> <p>Not covered</p> <p>\$4,000 deductible, then 50% coinsurance</p> <p>\$4,000 deductible, then 50% coinsurance</p> <p>\$4,000 deductible, then 50% coinsurance</p> <p>\$4,000 deductible, then 50% coinsurance</p> <p>\$4,000 deductible, then 50% coinsurance</p> <p>\$4,000 deductible, then 50% coinsurance</p>
<p>Professional Visits and Services You may have extra costs for other services like lab tests and facility charges. Also see Allergy Testing And Treatment and Therapeutic Injections.</p> <ul style="list-style-type: none"> Office and clinic visits Electronic visits (e-visits) Other professional services 	<p>\$30 or \$40 copay per visit, deductible waived</p> <p>\$30 or \$40 copay per visit, deductible waived</p> <p>\$2,000 deductible, then 20% coinsurance</p>	<p>\$4,000 deductible, then 50% coinsurance</p> <p>Not covered</p> <p>\$4,000 deductible, then 50% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Psychological and Neuropsychological Testing	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Rehabilitation Therapy <ul style="list-style-type: none"> • Outpatient Care calendar year visit limit: 15 visits 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 	<ul style="list-style-type: none"> \$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance 	<ul style="list-style-type: none"> \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Skilled Nursing Facility Care calendar year day limit: 120 days	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Spinal and Other Manipulations calendar year visit limit: 12 visits	\$30 copay per visit, deductible waived	\$4,000 deductible, then 50% coinsurance
Substance Use Disorder <ul style="list-style-type: none"> • Office and clinic visits • Other professional services • Inpatient care and residential facility care • Outpatient facility care 	<ul style="list-style-type: none"> \$30 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance 20% coinsurance, deductible waived 	<ul style="list-style-type: none"> \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Surgery (includes anesthesia and blood transfusions) See the Hospital and Surgical Center Care - Outpatient benefits for facility charges.	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Surgical Center Care - Outpatient	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance
Temporomandibular Joint Disorders (TMJ) Care <ul style="list-style-type: none"> • Office and clinic visits • Other professional services • Inpatient facility care 	<ul style="list-style-type: none"> \$30 or \$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance 	<ul style="list-style-type: none"> \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance
Therapeutic Injections	\$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Transgender Services <ul style="list-style-type: none"> Office and clinic visits Other professional services Inpatient facility care 	\$30 or \$40 copay per visit, deductible waived \$2,000 deductible, then 20% coinsurance \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% coinsurance \$4,000 deductible, then 50% 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>	\$2,000 deductible, then 20% coinsurance \$30 or \$40 copay per visit, deductible waived \$2,000 deductible, then 20% 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. Your deductible and coinsurance apply to facility charges.) <ul style="list-style-type: none"> Freestanding urgent care centers Urgent care centers attached to or part of a hospital 	\$30 or \$40 copay per visit, deductible waived \$200 copay per visit, then \$2,000 deductible, then 20% coinsurance	\$4,000 deductible, then 50% coinsurance \$200 copay per visit, then \$2,000 deductible, then 20% coinsurance
Virtual Care Interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment <ul style="list-style-type: none"> Virtual general medical visits Virtual mental health visits Virtual substance use disorder visits Virtual rehabilitative care 	\$10 copay per visit, deductible waived \$30 copay per visit, deductible waived \$30 copay per visit, deductible waived \$30 copay per visit, deductible waived	n/a n/a n/a n/a

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.
 - 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.

Contracted Health Care Benefit Managers

The list of Premera's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at <https://www.premera.com/visitor/companies-we-work-with> and changes to these contracts or services are reflected on the web site within 30 business days.

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). This means higher cost-shares for you, as shown in the **Summary Of Your Costs**.

- 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.
- **Non-Contracted Providers** 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.

Surprise Billing Protection

Non-contracted providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, Washington law protects you from surprise billing for:

Emergency Care from a non-contracted hospital in Washington, Oregon or Idaho or from a non-contracted provider that works at the hospital.

- The services below from a **non-contracted provider** at an **in-network hospital or outpatient surgery center in Washington**:
 - Surgery
 - Anesthesia
 - Pathology
 - Radiology
 - Laboratory
 - Hospitalist care

For the above services, you pay only the plan's in-network cost-shares, if any. See the **Summary Of Your Costs**. Premera Blue Cross will work with the non-contracted provider to resolve any issues about the amount paid. Premera will also send the plan's payments to the provider directly. The provider must refund any amounts you have overpaid within 30 business days after the provider receives the payment.

Please note: The surprise billing protection does not apply to any other service from a non-contracted provider. If the service is not listed above, you must pay any amounts over the plan's allowed amount for the service. Amounts you pay over the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

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.
- 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 named under **Surprise Billing Protection** earlier in the booklet.
- 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**.

COPAYMENTS (COPAYS)

Copayments ("copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service. If the amount billed is less than the copay, you only pay the amount billed. Your copay amounts are shown in the **Summary Of Your Costs**.

SPLIT COPAY FOR OFFICE VISITS

This plan has two Professional Visit Copay amounts for in-network providers' office and home visits. When you see one of the types of in-network providers shown below, you pay the non-specialist copay shown in the **Summary Of Your Costs** for each office or home visit.

- Family practice physician
- General practice physician
- Internist
- Gynecologist
- Naturopath
- Advanced registered nurse practitioner (ARNP)
- Obstetrician
- Pediatrician
- Physician assistant

- Chiropractor
- Acupuncturist

For all other types of in-network providers covered by benefits subject to a professional visit copay, you pay the specialist copay shown in the **Summary Of Your Costs** for each visit.

Certain services don't require a copay. However, the Professional Visit Copay may apply if you have a consultation with the provider or receive other services. Separate copays will apply if you see more than one in-network provider on the same day. But only one copay per provider, per day will apply. If you receive multiple services from the same provider in the same visit and the copay amounts are different, then the highest copay will apply.

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the 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 individual 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 either of your individual calendar year deductibles toward that maximum.

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

The plan has separate deductibles for in-network and out-of-network providers. **It could happen that you satisfy one of these deductibles before the other. If this happens, you still have to pay cost-shares that apply to the second deductible until it, too, is met.**

Individual Deductible

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

Family Deductible

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

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
- The penalty for not asking for prior authorization when the plan requires it. See **Prior Authorization** in the **Care Management** section of this booklet.
- The difference in cost between a brand name drug and an equivalent generic drug when the plan requires the generic drug to be dispensed in place of the brand name drug.
- Copays
- The calendar year prescription drug deductible and coinsurance for in-network pharmacies stated in the **Summary Of Your Costs**

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 copays and the calendar year deductible, when the plan provides benefits at less than 100% of the allowed amount. You will find your coinsurance in the **Summary Of Your Costs**.

OUT-OF-POCKET MAXIMUM

The “individual out-of-pocket maximum” is the maximum amount, made up of the cost-shares below, that each individual could pay each calendar year for certain covered services and supplies. Please refer to the **Summary Of Your Costs** for the amount of out-of-pocket maximums you're responsible for.

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

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

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

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

- Charges above the 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** benefit, will apply toward the out-of-pocket maximum.
- Your cost-shares for covered drugs purchased from out-of-network pharmacies.
- The penalty for not requesting prior authorization when needed. See **Pre-Approval** in the **Care Management** section of this booklet.

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

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, coinsurance, copays 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**

Except as stated below, 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 Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

- An amount that is no less than the lowest amount 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 as implemented by Premera
- 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.

Non-Emergency Services Protected From Surprise Billing

A different rule applies to certain services from a non-contracted provider at an in-network hospital or outpatient surgery center in Washington. The services are surgery, anesthesia, pathology, radiology, laboratory, and hospitalist care. For these services, the allowed amount is the median in-network rate for the same or similar service in the same or similar geographic area.

Dialysis Due To End Stage Renal Disease

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

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

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

The amount the plan allows for dialysis during Medicare's waiting period will be no less than 300% 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 for non-contracted providers 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

You do not have to pay amounts over the allowed amount for emergency care from non-contracted providers in Washington, Oregon, or Idaho.

If the non-contracted provider is not in Washington, Oregon or Idaho, you will be responsible for charges received from out-of-network providers above the allowed amount along with your deductible, copays and coinsurance.

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

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

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

The technique of inserting thin needles through the skin at specific points on body to help control pain and other symptoms. Services must be provided by a certified or licensed acupuncturist.

This benefit covers acupuncture to:

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

Allergy Testing and Treatment

Skin and blood tests used to diagnose what substances a person is allergic to, and treatment for allergies. Services must be provided by a certified or licensed allergy specialist.

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:

- Transport takes you to the nearest available facility that can treat your condition
- The above requirements for ambulance services are met
- Geographic restraints prevent ground transport
- 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.

This benefit does not cover:

- Services from an unlicensed ambulance

Blood Products And Services

- Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider.
- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.

Cellular Immunotherapy And Gene Therapy

Treatment which uses your body's own immune system or genes to treat disease.

These therapies are fairly new, and their use is evolving. They must meet three criteria in order to be covered:

- Prescribed by a doctor
- Meet Premera's medical policy (See premera.com or call customer service), and
- Approved by Premera before they can happen (See **Prior Authorization**)

This benefit covers:

Medically necessary cellular immunotherapy and gene therapy, like CAR-T

If you travel more than 50 miles for these therapies, keep all receipts. You can be reimbursed for some expenses, up to \$7,500 per episode of care. See **Medical Transportation**.

See **Prior Authorization** for more information on getting prior approval for services.

Chemotherapy And Radiation Therapy

Treatment which uses powerful chemicals (chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells.

Chemotherapy and radiation must be prescribed by a doctor and approved by Premera to be covered. See **Prior Authorization**.

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit
- Tooth extraction to prepare your jaw for radiation therapy

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

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

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

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

Diagnostic x-ray, lab and imaging services are basic and major medical tests that help find or identify diseases.

The same test, like a colonoscopy, can be either Preventive or Diagnostic. If the test was ordered to evaluate a sign, symptom or health concern, it is Diagnostic. A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See **Prior Authorization** for details.

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
- Diagnosis and treatment of underlying medical conditions that may cause infertility
- 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:

- **Emergency Room**

- Hospital
- Maternity Care
- Preventive Care
- Genetic testing may be covered in some cases. Call customer service before seeking testing, since it may require Prior Authorization.

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

This benefit does not cover testing required for employment, schooling, screening or public health reasons that is not for the purpose of treatment.

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**.

In-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. See **Allowed Amount** in **Important Plan Information** for more information.

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. This includes emergency services arising from complications from a service that was not covered by the plan.
- 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

General Home Health Care

General Home Health Care is short-term care performed at your home. These occasional visits are done by a medical professional that's employed through a home health agency that is state-licensed or Medicare-certified. Care is covered when a doctor states in writing that care is needed in your home.

The following are covered under the **Home Health Care** benefit:

- 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 certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

Skilled Hourly Nursing

Skilled Hourly Nursing is also covered under the **Home Health Care** benefit. Skilled Hourly Nursing is medically intensive care at home that is provided by a licensed nurse.

Skilled Hourly Nursing is covered only when provided in lieu of hospitalization.

You must have a written plan of care from your doctor and requires prior authorization by the plan. See **Prior Authorization**. This type of care is not subject to any visit limit shown in the **Summary of Your Costs**.

The **Home Health Care** benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Private duty nursing that is not General Home Health Care or Skilled Hourly Nursing
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food.

Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies

This benefit covers:

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 to correct vision due to the following medical eye conditions:

- 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
- Aniseikonia
- Anisometropia
- Corneal disorders
- Pathological myopia
- Post-traumatic disorders

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**).

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, transportation, and household supplies; housekeeping services other than those of a home health aide as prescribed by the plan of care

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

Mastectomy and Breast Reconstruction

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

- 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 provider such as 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. Prior approval is 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 for the member and one companion for cellular immunotherapy and gene therapy. 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

Transplants: You must pay for all travel expenses yourself and submit a Travel Claim Form.

Cellular Immunotherapy, and Gene Therapy: You must pay for all travel expenses yourself and submit a Travel Claim Form.

A separate Travel 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, other than 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 interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Please see the **Virtual Care** benefit.
- 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 substance use disorder 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
- 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 that 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

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

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

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.

Hospital Care

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

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

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.

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.

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

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.

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.

Birth Control

All FDA-approved female and male prescription and over-the-counter oral birth control drugs supplies and devices. See **Prescription Drug** in the **Summary Of Your Costs**. You must buy over-the-counter supplies and devices at the pharmacy counter. You do not need a prescription. For sterilization, shots or devices from your doctor, see **Preventive Care**.

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

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 Pharmacy Benefits** for exceptions to the supply limits shown in this table.

Pharmacy	Supply Limit	Instructions
In-Network Retail or In-Network Specialty Pharmacies	30 days	Pay the cost-share in the Summary Of Your Costs at the pharmacy
Out-Of-Network Retail Pharmacies	30 days	<ul style="list-style-type: none"> Pay the full cost of the drug at the pharmacy. Send Premera a claim. See How Do I File A Claim? in this booklet for instructions.
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.

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
- 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. Please see the **Infusion Therapy** benefit.
- Drugs to treat sexual dysfunction
- Drugs to manage your weight
- Medical equipment and supplies. See the **Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies** benefit for coverage.
- Immunization agents and vaccines.
- Drugs for fertility treatment or assisted reproduction procedures.

Questions and Answers About Your Pharmacy Benefits

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

Your coverage for drugs is not restricted to drugs on a specific list. This plan does make use of a list of drugs, 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 on drugs and their uses to choose safe and effective drugs for the list.

This plan does cover non-preferred brand name drugs, but at a higher cost to you. However, this plan doesn't cover certain categories of drugs. These are listed under **Exclusions** earlier in this benefit.

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

Generic Drug Substitution

This plan requires the use of appropriate generic drugs (as defined below). When available, a generic drug will be dispensed in place of a brand name drug. If there is no generic equivalent, you pay only the applicable brand name cost-share. See the **Summary Of Your Costs** for the amount you pay. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you will have to pay the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Please ask your pharmacist about the higher costs you will pay if you select a brand name drug.

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

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

Exceptions You or your provider may ask that the plan cover a brand name drug instead of a generic equivalent without a penalty. To waive the penalty, your provider must show that 1 of 3 things is true:

- You cannot tolerate the generic equivalent drug
- The drug is not safe or effective for your condition
- The dosage you need is not available in a generic equivalent drug.

If your request is approved, you pay only the applicable brand name cost-share shown in the **Summary Of Your Costs**. If your request is not approved, you will pay the penalty described under **Generic Drug Substitution** above.

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 15 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 72 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 72 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. It can decide to make a drug preferred or non-preferred at any point in the year. This can happen if new drugs appear on the market or new medical studies or other clinical information warrant the change.

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

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

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can 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. Please see **Prior Authorization** for more information about prior authorization.

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 receive the highest level of benefits when you have your prescriptions filled by in-network pharmacies. The majority of retail pharmacies in Washington are part of our pharmacy network. Your benefit covers prescription drugs dispensed from an out-of-network pharmacy, but at a higher out-of-pocket cost to you as explained above.

Our mail order program offers lower cost-shares and lets you buy larger supplies of your medications, but you must use our in-network mail order 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 without paying another copay or other repeating charge?

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the mail-order pharmacy benefit are described in the **Getting Prescriptions Filled** table above.

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

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

- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill. This rule does not apply when a 12-month supply of birth control drugs has been dispensed in one fill or 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. If you must pay a copay for the drug, the full copay is required for the early refill.
- 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.
- Up to a 12-month supply of birth control drugs can be dispensed on request. If you must pay a copay for the drug, you pay one copay for each 30-day supply from a retail pharmacy or one copay for each 90-day supply from the in-network mail-order pharmacy.

The plan can also cover more than the 30-day or 90-day supply limit if the drug maker's packaging does not let the exact amount be dispensed. If you must pay a copay for the drug, you pay one copay for each 30-day supply from a retail pharmacy or one copay for each 90-day supply from the in-network mail-order pharmacy.

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

This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by a licensed pharmacy. Other services, such as consultations with a pharmacist, diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Drug Discount Programs

Pharmacy Benefit Drug Program For pharmacy benefit claims, Premera Blue Cross will pay the Group 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 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 a 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 45 or older or who are under age 45 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

- Birth control devices, shots and implants. The plan will cover up to a 12-month supply of birth control pills you receive in your provider's office.
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**.
- Vasectomy done in a doctor's office with a local anesthetic

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
- Services related to tubal ligation when it is done as a secondary procedure. The charge for the procedure itself is covered under this benefit, but the related services, such as anesthesia, are covered as part of the primary procedure. Please see the **Hospital Inpatient** and **Surgery** benefits.
- Routine vision and hearing exams
- Gym fees or exercise classes or programs
- Services or tests for a specific illness, injury or set of symptoms. Please see the plan's other benefits.
- Physical exams for basic life or disability insurance
- Work-related disability or medical disability exams
- Purchase of hospital-grade breast pumps.

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

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 Health Care*** and ***Hospice Care*** benefits.

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.

Electronic Visits

This benefit will cover electronic visits (e-visits) from in-network providers when all the requirements below are met. This benefit is only provided when three things are true:

- Premera Blue Cross has approved the physician for e-visits. Not all physicians have agreed to or have the software capabilities to provide e-visits.
- The member has previously been treated in the approved physician's office and has established a patient-physician relationship with that physician.
- The e-visit is medically necessary for a covered illness or injury.

An e-visit is a structured, secure online consultation between the approved physician and the member. Each approved physician will determine which conditions and circumstances are appropriate for e-visits in their practice.

Please call Customer Service at the number shown on the back cover of this booklet for help in finding a physician approved to provide e-visits.

The Professional Visits And Services benefit doesn't cover:

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

Psychological and Neuropsychological Testing

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 medically necessary outpatient therapy:

- Physical, speech, hearing and occupational therapies. Physical, speech, and occupational assessments and evaluations related to rehabilitation are also covered.
- Premera Blue Cross reviews proposed outpatient physical, occupational, and massage therapy for medical necessity before you receive the care. Your first visit to the therapist and the next six visits are not subject to this review. There is no penalty to you if your provider does not ask for the review before providing the care. The review will then be done at the time the claim is submitted.
- Cardiac and pulmonary rehabilitation programs.
- Cochlear implants
- Home medical equipment, medical supplies and devices

This benefit does not cover:

- Pulmonary rehabilitation and cardiac rehabilitation. See **Professional Visits And Services** for coverage.
- 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.

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 **Rehabilitation Therapy** and **Neurodevelopmental Therapy** benefits.

Substance Use Disorder

This benefit covers inpatient and outpatient substance use disorder and supporting services.

Covered services include services provided by a state-approved treatment program or other licensed or certified provider. Covered outpatient visits can include interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Please see the **Virtual Care** benefit.

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 substance use disorder 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** and **Hospital** 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.

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.

Surgical Center Care – Outpatient

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

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 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

Benefits for medically necessary transgender services are subject to the same cost-shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages. To find the amounts you are responsible for, please see the Summary of Your Costs earlier in this booklet.

Benefits are provided for all transgender surgical services which meet the Premera medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from Customer Service, or at www.premera.com.

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of transgender surgery, are covered under the surgical benefits applicable to those conditions.

Please Note: Coverage of prescription drugs, and mental health treatment associated with gender reassignment surgery, are eligible under the general plan provisions for prescription drugs and behavioral health, subject to the applicable plan limitations and exclusions.

Transplants

The **Transplants** benefit is not subject to a separate benefit maximum other than the maximum for travel and lodging described below. This benefit covers medical services only if provided by 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 other than bone marrow or stem cells. These procedures are covered on the same basis as any other covered surgical procedure (please see the **Surgeries** 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 other approval standards we use.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

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

Recipient Costs

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

Donor Costs

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

Travel And Lodging

Benefits are provided for certain travel expenses related to services provided by an approved transplant provider. 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, that are not 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

Virtual care uses interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Services must meet the following requirements:

- Covered service under this plan
- Originating site: Hospital, Rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center
- If the service is provided through store and forward technology, there must be an associated office visit between the member and the referring provider.
- Is Medically Necessary

See the **Summary Of Your Costs** for the types of virtual visits covered by this benefit.

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

OUT-OF-AREA CARE

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

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' 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.

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 in Clark County, Washington and outside Washington and Alaska that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. Please see **Allowed Amount** in **Important Plan Information** 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.

If you do not ask for prior authorization, and the plan covers the service, you will have to pay a penalty.

The amount is 50% of the allowed amount. However, you will not have to pay more than \$1,500 per occurrence. You also have to pay your cost-share.

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:

- The first six visits provided by an in-network provider for rehabilitation and habilitation therapy, spinal manipulative treatment or acupuncture.
- 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.

CHRONIC CONDITION MANAGEMENT

Premera has contracted with a consumer digital health company (the program manager) to give members access a program of monitoring and health management support for certain chronic conditions described below. The program is voluntary. Your readings and other data are not shared with Premera, Gesa Credit Union or anyone other than the program manager. However, the program manager can share your data with your doctor or with someone close to you if you choose.

Diabetes

For members who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:

- A blood glucose meter from the program manager that uploads blood sugar readings to a personal online account.
- A lancing device and lancets.
- Test strips for this meter. You can reorder test strips using the meter or online. The strips will be sent to you directly.
- Real-time reminders to check blood sugar or to take medication, and tips based on your blood sugar readings that can help keep your levels within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app.

High Blood Pressure

If you qualify and join the program, you will get:

- A blood pressure cuff from the program manager that uploads blood pressure readings to a personal online account.
- Real-time reminders to check blood pressure or to take medication, and tips based on your blood pressure readings that can help keep your pressure within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app. Access to online information.

EXCLUSIONS

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

Amounts Over The Allowed Amount

Costs over the allowed amount as defined by this plan, including services from a non-contracted provider.

Assisted Reproduction

Assisted reproduction technologies, including but not limited to:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures.
- Artificial insemination or assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure.

- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

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

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

Comfort or Convenience

- 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.
- 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.

Cosmetic Services

Drugs, services or supplies for cosmetic services not medically necessary.

Counseling, Education And Training

Counseling, education or training in the absence of illness including:

- 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

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.

Dental Care

This plan does not cover dental care.

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

EEG Biofeedback Or Neurofeedback Services

Environmental Therapy

Experimental or investigative services or supplies. This plan also does not cover any complications or effects of such non-covered services.

Experimental Or Investigative Services

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

Family Members Or Volunteers

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

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

Governmental Facilities

This plan does not cover services provided by a state or federal facility that are not emergency care unless required by law or regulation

Hair Loss

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

Illegal Acts and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt.

Laser Therapy

Low-level laser therapy.

Military Service And War

Illness or injury that is caused by or arises from:

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

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. .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

Institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered services. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes, camps and adult family homes.

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

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
- Hiking, tall ship, and other adventure programs and camps
- Boot camp programs and outward-bound 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.

Services or Supplies 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.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment, including drugs, medications, or penile or other implants

Vision Exams

This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.

Vision Hardware

This plan does not cover vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies, except as covered under the **Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies** benefit. This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

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

Voluntary Support Groups

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

Weight Loss Surgery or Drugs

This plan does not cover surgery, drugs or supplements for weight loss or weight control.

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 details, see **Third Party Recovery** under **What If I Have Other Coverage**.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

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 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
 - 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:

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
 - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. If the parent who is responsible has no health coverage for the dependent, but that parent's spouse

does, that spouse's plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.

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

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

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

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

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

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

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 benefits under:

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

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

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law

requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

Reimbursement and Subrogation Rights

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

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

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

Your Responsibilities

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

Claims for your injury shall not be paid until Premera Blue Cross receives a completed copy of the Incident Questionnaire when one was sent.

- You must tell Premera Blue Cross if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

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

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

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

WHO IS ELIGIBLE FOR COVERAGE?

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

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

SUBSCRIBER ELIGIBILITY

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

- The employee must be a regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group's payroll system, and reported by the Group for Social Security purposes. The employee must also:
 - Regularly work a minimum of 30 hours per week
 - Satisfy a probationary period, if one is required by the Group

Employees Performing Employment Services In Hawaii

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

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated. ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction.
- The domestic partner of the subscriber. Domestic partnerships that are **not** documented in a state domestic partnership registry must meet all requirements stated in the signed "Affidavit of Domestic Partnership." All rights, benefits and obligations afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible dependent child who is under 26 years of age.

An eligible child is one of the following:

- A natural offspring of either or both the subscriber or spouse
- A legally adopted child of either or both the subscriber or spouse

- A child placed with the subscriber for the purpose of legal adoption in accordance with state law. “Placed” for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
- A legally placed ward or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

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

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

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

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

Dependents Through Marriage After The Subscriber's Effective Date

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

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

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

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

Adoptive Children On Or After The Subscriber's Effective Date

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

Foster Children

To enroll a new foster child, we must get any payment needed, a completed enrollment form, and a copy of the child's foster papers. We must get these items no more than 60 days after the date the subscriber became the child's foster parent. When we get these items on time, the plan will cover the child as of the date the subscriber became the child's foster parent. If we do not get the items on time, the child must wait for the Group's next open enrollment period to be enrolled.

Children Through Legal Guardianship

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

Children Covered Under Medical Child Support Orders

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

SPECIAL ENROLLMENT

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

Involuntary Loss of Other Coverage

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

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

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

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

Subscriber And Dependent Special Enrollment

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

State Medical Assistance and Children's Health Insurance Program

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

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

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

OPEN ENROLLMENT

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

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

CHANGES IN COVERAGE

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

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

PLAN TRANSFERS

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

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

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

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

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

- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she cannot meet the requirements for dependent coverage shown under the ***Who Is Eligible For Coverage?*** section.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

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

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes the Group with a Request for Certification of Handicapped Dependent form. The Group must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

LEAVE OF ABSENCE

Family and Medical Leave Act

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

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

- FMLA also lets employees take up to 26 weeks of leave during a 12-month period to care for a spouse, child, parent or next of kin who is a covered member of the armed forces and who has a serious injury or illness. “Covered member of the armed forces” also means a veteran who was discharged from the armed forces (other than a dishonorable discharge) at any time during the 5 years before the FMLA leave starts.

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

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

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

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

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

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

Other Leaves of Absence

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

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

LABOR DISPUTE

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

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

COBRA

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

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

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

Qualifying Events And Length Of Coverage

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

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

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
 - **The subscriber's work hours are reduced.**

- **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

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

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

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

Conditions Of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

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

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

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

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

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

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

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

of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

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

You Must Enroll And Pay On Time

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

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

- You must send your first payment to the Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly payments must also be paid to the Group.

Adding Family Members

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

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

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

If You Have Questions

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

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than as described under ***Intentionally False Or Misleading Statements***.

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

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

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

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

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

CONTINUATION UNDER USERRA

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

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

MEDICARE SUPPLEMENT COVERAGE

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

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

Step 1

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

Step 2

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

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or 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 have to pay the full cost of the prescription and submit the claim yourself.

For mail-order pharmacy purchases, you don't have to send us a claim, but you'll need to follow the instructions on the order form and submit it to the address printed on the form. Please allow up to 14 days for delivery.

Out-Of-Network Pharmacies

You'll have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You'll need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

If you need a supply of in-network mail-order pharmacy order forms or prescription drug claim forms, contact our Customer Service department at the numbers shown on the back cover of this booklet.

Timely Filing

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

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies

- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

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

Special Notice About Claims Procedure

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

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

- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information 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.
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](https://www.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 Premera Blue Cross and the Group are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.

Intentionally False Or Misleading Statements

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

WHAT ARE MY RIGHTS UNDER ERISA?

This plan is an employee welfare benefit plan that's 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.

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

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

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. 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 **Special Enrollment** provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

Emergency Care

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

Essential Health Benefits

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

Experimental/Investigational Services

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

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition

- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

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

Group

The entity that sponsors this self-funded plan.

Health Care Benefit Managers

Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.

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/In-Network Mail Order 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. 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.

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. Home) with a provider that is diagnostic and treatment focused. The member is not located at a healthcare site.

We, Us and Our

Means Premera Blue Cross.

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Manager At

1-800-391-9701
www.express-scripts.com

Customer Service

Mailing Address

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

Physical Address

3900 East Sprague
Spokane, WA 99202-4895

Phone Numbers

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

Local and toll-free TTY number:
711

Care Management

Prior Authorization And Emergency Notification

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

Local and toll-free number:
1-800-722-1471
Fax: 1-800-843-1114

Complaints And Appeals

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

BlueCard

1-800-810-BLUE(2583)

Website

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



**Gesa
Credit
Union**

Your Future™ *

4000063

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

Gesa Credit Union 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. Gesa Credit Union 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: Gesa Credit Union

Effective Date: January 1, 2022

Group Number: 4000063

Plan: Your Future (Non-Grandfathered)

Certificate Form Number: 40000630122YF

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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដោយមិនគិតថ្លៃ 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).

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

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

यिआन दिउ: ने तुमी पंजाबी बोलते हे, तं त्रामा विंच सगदिता सेवा तुवाडे लखी मुदत छुपलसयन है। 800-722-1471 (TTY: 711) 'ते वाल बते।

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

ໂປດຄຳບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

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

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

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

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

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

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

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:

- **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
- **Prior Authorization** – Describes the plan's prior authorization and emergency admission notification requirements.
- **Exclusions** — services that are either limited or not covered under this plan
- **Who Is Eligible For Coverage?** – eligibility requirements for this plan
- **How Do I File A Claim?** — step-by-step instructions for claims submissions
- **Complaints And Appeals** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: “You” and “your” refer to members under this plan. “We,” “us” and “our” 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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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***.
- 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. See ***Important Plan Information*** for more details.

	In-Network Providers	Out-of-Network Providers
Individual deductible	\$5,000	\$10,000
Family deductible (not shown in the summary table)	\$10,000	\$20,000

- **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.

	In-Network Providers	Out-of-Network Providers
Coinsurance	0%	50%

- 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
Individual out-of-pocket maximum	\$5,000	None
Family out-of-pocket maximum	\$10,000	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 individual deductible. The family 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 Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
Acupuncture Calendar year visit limit: 12 visits	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Allergy Testing And Treatment	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Ambulance	\$5,000 deductible, then 0% coinsurance	\$5,000 deductible, then 0% coinsurance
Blood Products and Services	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% 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	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Clinical Trials Covers routine patient care during the trial	Covered as any other service	Covered as any other service
Dental Care <ul style="list-style-type: none"> • Dental Anesthesia (up to age 19 when medically necessary) <ul style="list-style-type: none"> • Inpatient facility care • Outpatient surgery center • Anesthesiologist • Dental Injury 	<p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p>	<p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p>
Diagnostic X-Ray, Lab And Imaging for medical conditions or symptoms Tests, lab, imaging and scans	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Dialysis For permanent kidney failure. See the Dialysis benefit for details. <ul style="list-style-type: none"> • During Medicare's waiting period • After Medicare's waiting period 	<p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, no coinsurance</p>	<p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, no coinsurance</p>
Emergency Room <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>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p>	<p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
Foot Care such as trimming nails or corns, when medically necessary due to a medical condition	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Home Health Care calendar year limit: 130 visits • Home visits • Prescription drugs billed by the home health agency	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies • Sales tax for covered items • Foot orthotics and therapeutic shoes; calendar year limit: \$300 except diabetes-related • Medical vision hardware	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance
Hospice Care Lifetime limit for terminal illness: 6 months Lifetime limit for non-terminal illness: none Inpatient stay limit: 10 days Home visits: Unlimited Respite care: 240 hours • Inpatient facility care • Home and respite care • Prescription drugs billed by the hospice	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance
Hospital • Inpatient Care • Professional • Facility • Outpatient Care • Professional • Facility	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance
Infusion Therapy	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
Mastectomy and Breast Reconstruction <ul style="list-style-type: none"> Office and clinic visits, surgery, and other professional services Inpatient facility care 	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% 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 	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance
Medical Foods includes phenylketonuria (PKU)	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Medical Transportation Travel and lodging are covered up to the IRS limitations. Prior approval required For transplants: limit per transplant: \$7,500 For cellular immunotherapy and gene therapy: \$7,500 per episode of care Special criteria are required for travel benefits to be provided. Please see the benefit for coverage details.	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance
Mental Health Care <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient and residential facility care Outpatient facility care 	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance
Neurodevelopmental Therapy (Habilitation) See the Mental Health Care benefit for therapies for mental conditions such as autism. <ul style="list-style-type: none"> Outpatient care calendar year visit limit: 15 visits 	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
<ul style="list-style-type: none"> Inpatient care calendar year day limit: 30 days 	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Newborn Care <ul style="list-style-type: none"> Inpatient care Outpatient care 	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance
Prescription Drug In no case will you pay more than the cost of the drug or supply. Per Internal Revenue Service requirements, drug manufacturer's coupons and other forms of cost-share assistance cannot be used to satisfy this plan's deductible.		
Covered Drugs Generic and brand-name drugs	In-Network Retail Pharmacy Individual deductible shown Family deductible is 2X Individual \$5,000 deductible, then 0% coinsurance	Out-Of-Network Retail Pharmacy Individual deductible shown Family deductible is 2X Individual \$5,000 deductible, then 0% coinsurance
Generic and brand-name drugs	In-Network Mail-Order Pharmacy \$5,000 deductible, then 0% coinsurance	Out-Of-Network Mail-Order Pharmacy Not covered
Specialty Drugs Specialty drugs	In-Network Pharmacy \$5,000 deductible, then 0% coinsurance	Out-Of-Network Pharmacy Not covered
<i>*Your cost-shares for covered prescription insulin drugs will not exceed \$100 per 30-day supply of the drug. The deductible does not apply. Cost-shares for covered prescription insulin drugs apply toward the deductible.</i>		
PV Core Preventive Drugs Generic and brand-name drugs	No charge	No charge
Exceptions <ul style="list-style-type: none"> Certain prescription drugs and generic over-the-counter drugs to break a nicotine habit 	In-Network Retail or In-Network Mail Order Pharmacy No charge	Out-Of-Network Retail Pharmacy No cost-shares

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
<ul style="list-style-type: none"> • 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. • Male birth control devices and supplies (prescription and over-the-counter) 	<p>No charge</p> <p>No charge</p> <p><u>Subscriber alone</u>: must meet \$1,400 of the \$5,000 deductible <u>Subscriber and dependents</u>: must meet \$2,800 of the \$10,000 deductible</p>	<p>No cost-shares</p> <p>Same as out-of-network retail</p> <p>Same as out-of-network retail</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 • Fall prevention for members 65 and older • Immunizations in the doctor's office • Flu shots and other seasonal immunizations at a pharmacy or mass immunizer location • Travel immunizations at a travel clinic or county health department • Health education and training (outpatient) • Nicotine habit-breaking programs • Nutritional counseling and therapy • Pregnant women's care (includes breast-feeding support and post-partum depression screening) • Screening tests (includes prostate and cervical cancer screening) • Screening mammograms • Colon cancer screening • Female birth control and sterilization 	<p>In-Network Providers</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>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Out-of-Network Providers</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>No cost-shares</p> <p>No cost-shares</p> <p>Not covered</p> <p>Not covered</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
<ul style="list-style-type: none"> Male birth control and sterilization (Vasectomy covered as preventive only if done in a doctor's office under local anesthetic) 	<p>Subscriber alone: must meet \$1,400 of the \$5,000 deductible</p> <p>Subscriber and dependents: must meet \$2,800 of the \$10,000 deductible</p>	\$10,000 deductible, then 50% coinsurance
<p>Professional Visits and Services Also see Allergy Testing And Treatment and Therapeutic Injections.</p> <ul style="list-style-type: none"> Office and clinic visits Electronic visits (e-visits) Other professional services 	<p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p>	<p>\$10,000 deductible, then 50% coinsurance</p> <p>Not covered</p> <p>\$10,000 deductible, then 50% coinsurance</p>
<p>Psychological and Neuropsychological Testing</p>	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
<p>Rehabilitation Therapy</p> <ul style="list-style-type: none"> Outpatient Care calendar year visit limit: 15 visits No limit for cardiac or pulmonary rehabilitation programs, or similar programs for cancer or other chronic conditions. <ul style="list-style-type: none"> Office and clinic visits Other outpatient services Inpatient Care calendar year day limit: 30 days 	<p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p>	<p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p>
<p>Skilled Nursing Facility Care calendar year day limit: 60 days</p>	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
<p>Spinal and Other Manipulations calendar year visit limit: 12 visits</p>	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
<p>Substance Use Disorder</p> <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient care and residential facility care Outpatient facility care 	<p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p> <p>\$5,000 deductible, then 0% coinsurance</p>	<p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p> <p>\$10,000 deductible, then 50% coinsurance</p>

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
Surgery (includes anesthesia and blood transfusions) See the Hospital and Surgical Center Care -- Outpatient benefits for facility charges.	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Surgical Center Care – Outpatient	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Temporomandibular Joint Disorders (TMJ) Care <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient facility care 	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% coinsurance
Therapeutic Injections	\$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance
Transgender Services <ul style="list-style-type: none"> Professional services, such as office or inpatient visits Inpatient facility care 	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$10,000 deductible, then 50% 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>	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% 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 	\$5,000 deductible, then 0% coinsurance \$5,000 deductible, then 0% coinsurance	\$10,000 deductible, then 50% coinsurance \$5,000 deductible, then 0% coinsurance

BENEFIT	YOUR SHARE OF THE ALLOWED AMOUNT	
	IN-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual	OUT-OF-NETWORK PROVIDERS Individual deductible shown Family deductible is 2X Individual
Virtual Care Interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment.		
Virtual general medical visits	\$5,000 deductible, then 0% coinsurance	n/a
Virtual mental health visits	\$5,000 deductible, then 0% coinsurance	n/a
Virtual substance use disorder visits	\$5,000 deductible, then 0% coinsurance	n/a
Virtual rehabilitative care visits	\$5,000 deductible, then 0% coinsurance	n/a

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.
 - 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.

Contracted Health Care Benefit Managers

The list of Premera's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at <https://www.premera.com/visitor/companies-we-work-with> and changes to these contracts or services are reflected on the web site within 30 business days.

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.
- **Non-Contracted Providers** 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.

Surprise Billing Protection

Non-contracted providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, Washington law protects you from surprise billing for:

Emergency Care from a non-contracted hospital in Washington, Oregon or Idaho or from a non-contracted provider that works at the hospital.

- The services below from a **non-contracted provider** at an **in-network hospital or outpatient surgery center in Washington**:
 - Surgery
 - Anesthesia
 - Pathology
 - Radiology
 - Laboratory
 - Hospitalist Care

For the above services, you pay only the plan's in-network cost-shares, if any. See the **Summary of Your Costs**. Premera Blue Cross will work with the non-contracted provider to resolve any issues about the amount paid. Premera will also send the plan's payments to the provider directly. The provider must refund any amounts you have overpaid within 30 business days after the provider receives the payment.

Please note: The surprise billing protection does not apply to any other service from a non-contracted provider. If the service is not listed above, you must pay any amounts over the plan's allowed amount for

the service. Amounts you pay over the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

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.

- 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 named under **Surprise Billing Protection** earlier in the booklet.
- 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).

The plan has separate deductibles for in-network and out-of-network providers. **It could happen that you satisfy one of these deductibles before the other. If this happens, you still have to pay cost-shares that apply to the second deductible until it, too, is met.**

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.

Individual Deductible

An individual deductible is the amount each member must incur and satisfy before certain benefits of this plan are provided.

Family Deductible

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

individual deductible before the family deductible is met, the plan will provide benefits that are subject to the deductible for that person.

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
- The penalty for not requesting prior authorization when needed. See **Prior Authorization** in the Care Management section of this booklet.
- Drug manufacturer coupons and other forms of cost-share assistance per Internal Revenue Service requirements.

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

The "individual out-of-pocket maximum" is the maximum amount that 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.

We keep track of the amounts applied to the individual out-of-pocket maximums of all enrolled family members combined. When the total equals a set maximum, called the family out-of-pocket maximum, we will consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year. Only the amounts used to satisfy each enrolled family member's individual out-of-pocket maximum will count toward the family out-of-pocket maximum.

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

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.
- The penalty for not requesting prior authorization when needed. See **Prior Authorization** in the Care Management section of this booklet.
- If you participate in a Health Savings Account (HSA) – Drug manufacturer coupons and other forms of cost-share assistance, per Internal Revenue Service requirements.

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, coinsurance, copays 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**

Except as stated below, 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 Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

- An amount that is no less than the lowest amount 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 as implemented by Premera
- 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.

Non-Emergency Services Protected From Surprise Billing

A different rule applies to certain services from a non-contracted provider at an in-network hospital or outpatient surgery center in Washington. The services are surgery, anesthesia, pathology, radiology, laboratory, and hospitalist care. For these services, the allowed amount is the median in-network rate for the same or similar service in the same or similar geographic area.

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 300% 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 for non-contracted providers 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

You do not have to pay amounts over the allowed amount for emergency care from non-contracted providers in Washington, Oregon, or Idaho.

If the non-contracted provider is not in Washington, Oregon or Idaho, you will be responsible for charges received from out-of-network providers above the allowed amount along with your deductible, copays and coinsurance.

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

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

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

The technique of inserting thin needles through the skin at specific points on body to help control pain and other symptoms. Services must be provided by a certified or licensed acupuncturist.

This benefit covers acupuncture to:

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

Allergy Testing and Treatment

Skin and blood tests used to diagnose what substances a person is allergic to, and treatment for allergies. Services must be provided by a certified or licensed allergy specialist.

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:

- Transport takes you to the nearest available facility that can treat your condition
- The above requirements for ambulance services are met
- Geographic restraints prevent ground transport
- 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.

This benefit does not cover:

- Services from an unlicensed ambulance

Blood Products and Services

- Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider.
- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.

Cellular Immunotherapy And Gene Therapy

Benefits are provided for medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy. 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**.

Chemotherapy And Radiation Therapy

Treatment which uses powerful chemical (chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells.

Chemotherapy and radiation must be prescribed by a doctor and approved by Premera to be covered. See **Prior Authorization**

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit
- Tooth extractions to prepare your jaw for radiation therapy

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

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

Diagnostic x-ray, lab and imaging services are basic and major medical tests that help find or identify diseases.

The same test, like a colonoscopy, can be either Preventive or Diagnostic. If the test was ordered to evaluate a sign, symptom or health concern, it is Diagnostic. A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See **Prior Authorization** for details.

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

- Diagnosis and treatment of the underlying medical conditions that may cause infertility
- 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:

- Emergency Room
- Hospital
- Maternity Care
- Preventive Care
- Genetic testing may be covered in some cases. Call customer service before seeking testing, since it may require Prior Authorization.

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

This benefit does not cover testing required for employment, schooling, screening or public health reasons that is not for the purpose of treatment.

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. This includes emergency services arising from complications from a service that was not covered by the plan.
- 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

General Home Health Care

General Home Health Care is short-term care performed at your home. These occasional visits are done by a medical professional that's employed through a home health agency that is state-licensed or Medicare-certified. Care is covered when a doctor states in writing that care is needed in your home.

The following are covered under the **Home Health Care** benefit:

- 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 certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

Skilled Hourly Nursing

Skilled Hourly Nursing is also covered under the Home Health Care benefit. Skilled Hourly Nursing is medically intensive care at home that is provided by a licensed nurse.

Skill Hourly Nursing is covered only when provided in lieu of hospitalization.

You must have a written plan of care from your doctor and requires prior authorization by the plan. See **Prior Authorization**. This type of care is not subject to any visit limit shown in the **Summary of Your Costs**.

The **Home Health Care** benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Private duty nursing that is not **General Home Health Care** or **Skilled Hourly Nursing**
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food

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 to correct vision due to the following medical eye conditions:

- 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
- Aniseikonia
- Anisometropia
- Corneal disorders
- Pathological myopia
- Post-traumatic disorders

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. This includes housekeeping done by a home health aide that is included in the written plan of care.
- **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, transportation, and household supplies

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

Mastectomy and Breast Reconstruction

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 approval 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 for the member and one companion for cellular immunotherapy and gene therapy. 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

Transplants: You must pay for all travel expenses yourself and submit a Travel Claim Form.

Cellular Immunotherapy, and Gene Therapy: You must pay for all travel expenses yourself and submit a Travel Claim Form.

A separate Travel 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, other than 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 interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Please see the **Virtual Care** benefit.
- 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
- 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

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

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

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.

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.

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.

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.

Birth Control

All FDA-approved female and male prescription and over-the-counter oral birth control drugs, supplies and devices. See **Prescription Drug** in the **Summary Of Your Costs**. You must buy over-the-counter supplies and devices at the pharmacy counter. You do not need a prescription. For sterilization, shots or devices from your doctor, see **Preventive Care**.

PV Core Preventive Drugs The plan also covers drugs on our PV Core list. PV Core drugs are effective in controlling health problems such as heart disease. Our Pharmacy Committee reviews the list throughout the year. They update the PV Core 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 PV Core 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

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 Pharmacy Benefits** for exceptions to the supply limits shown in this table.

Pharmacy	Supply Limit	Instructions
In-Network Retail Pharmacies	90 days	Pay the cost-share in the Summary Of Your Costs at the pharmacy
Out-Of-Network Retail Pharmacies	90 days	<ul style="list-style-type: none"> Pay the full cost of the drug at the pharmacy. Send Premera a claim. See How Do I File A Claim in this booklet for instructions.
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.
- 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. Please see the **Infusion Therapy** benefit.
- Drugs to treat sexual dysfunction
- Drugs to manage your weight
- Medical equipment and supplies. See the **Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies** benefit for coverage.
- Immunization agents and vaccines.
- Drugs for fertility treatment or assisted reproduction procedures.

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?

Your coverage for drugs is not restricted to drugs on a specific list. This plan does make use of a list of drugs, 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 on drugs and their uses to choose safe and effective drugs for the list.

This plan does cover drugs that aren't on the drug list on the same basis as drugs that are. However, this plan 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 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.

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. Changes to our drug list do not change your benefits.

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 benefit covers prescription drugs dispensed from an out-of-network pharmacy, but at a possible higher out-of-pocket cost to you.

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. This rule does not apply when a 12-month supply of birth control drugs has been dispensed in one fill or 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.
- Up to a 12-month supply of birth control drugs can be dispensed on request.

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

If you participate in a Health Savings Account (HSA) – Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy this plan's deductible.

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 45 or older or who are under age 45 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

- Birth control devices, shots and implants. The plan will cover up to a 12-month supply of birth control pills you receive in your provider's office.
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**.
- Vasectomy done in a doctor's office with a local anesthetic

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.

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

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.

Electronic Visits

This benefit will cover electronic visits (e-visits) from in-network providers when all the requirements below are met. This benefit is only provided when three things are true:

- Premera Blue Cross has approved the physician for e-visits. Not all physicians have agreed to or have the software capabilities to provide e-visits.
- The member has previously been treated in the approved physician's office and has established a patient-physician relationship with that physician.
- The e-visit is medically necessary for a covered illness or injury.

An e-visit is a structured, secure online consultation between the approved physician and the member. Each approved physician will determine which conditions and circumstances are appropriate for e-visits in their practice.

Please call Customer Service at the number shown on the back cover of this booklet for help in finding a physician approved to provide e-visits.

The Professional Visits And Services benefit doesn't cover:

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

Psychological and Neuropsychological Testing

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

Skilled Nursing Facility Care

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 ***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. Covered outpatient visits can include interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Please see the **Virtual Care** benefit.

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.

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 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

Benefits for medically necessary transgender services are subject to the same cost-shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages. To find the amounts you are responsible for, please see the **Summary of Your Costs** earlier in this booklet.

Benefits are provided for all transgender surgical services which of the medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from Customer Service, or at www.premera.com.

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of transgender surgery, are covered under the surgical benefits applicable to those conditions.

Please Note: Coverage of prescription drugs, and mental health treatment associated with gender reassignment surgery, are eligible under the general plan provisions for prescription drugs and behavioral health subject to the applicable plan limitations and exclusions.

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 other than bone marrow or stem cells. These procedures are covered on the same basis as any other covered surgical procedure (please see the **Surgeries** 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, that are not 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

Virtual care uses interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Services must meet the following requirements:

- Covered service under this plan
- **Originating site:** Hospital, Rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center
- If the service is provided through store and forward technology, there must be an associated office visit between the member and the referring provider.
- Is Medically Necessary

See the **Summary Of Your Costs** for the types of virtual visits covered by this benefit.

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 in Clark County, Washington and outside Washington and Alaska. These arrangements are called "Inter-Plan Arrangements." Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' 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.

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 in Clark County, Washington and outside Washington and Alaska that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. 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.premera.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.

If you do not ask for prior authorization, and the plan covers the service, you will have to pay a penalty. The amount is 50% of the allowed amount. However, you will not have to pay more than \$1,500 per occurrence. You also have to pay your cost-share.

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

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

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.

CHRONIC CONDITION MANAGEMENT

Premera has contracted with a consumer digital health company (the program manager) to give members access a program of monitoring and health management support for certain chronic conditions described below. The program is voluntary. Your readings and other data are not shared with Premera, Gesa Credit Union or anyone other than the program manager. However, the program manager can share your data with your doctor or with someone close to you if you choose.

Diabetes

For members who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:

- A blood glucose meter from the program manager that uploads blood sugar readings to a personal online account.
- A lancing device and lancets.
- Test strips for this meter. You can reorder test strips using the meter or online. The strips will be sent to you directly.
- Real-time reminders to check blood sugar or to take medication, and tips based on your blood sugar readings that can help keep your levels within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app.

Pre-Diabetes

For members who meet pre-diabetes criteria followed by the Centers for Disease Control. If you qualify and join the program, you will get:

- A digital scale from the program manager that uploads readings to a personal online account.
- Lessons that cover topics such as nutrition, activity and stress
- Coaching and support via phone, text, e-mail or the program manager's mobile app

High Blood Pressure

If you qualify and join the program, you will get:

- A blood pressure cuff from the program manager that uploads blood pressure readings to a personal online account.
- Real-time reminders to check blood pressure or to take medication, and tips based on your blood pressure readings that can help keep your pressure within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app. Access to online information.

EXCLUSIONS

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

Amounts Over The Allowed Amount

Costs over the allowed amount as defined by this plan, including services from a non-contracted provider.

Assisted Reproduction

Assisted reproduction technologies, including but not limited to:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures.
- Artificial insemination or Assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure.
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

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

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

Comfort or Convenience

- 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.
- 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.

Cosmetic Services

Drugs, services or supplies for cosmetic services not medically necessary.

Counseling, Education And Training

Counseling, education or training in the absence of illness including:

- 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

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.

Dental Care

This plan does not cover dental care.

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

EEG Biofeedback or Neurofeedback Services

Environmental Therapy

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

Experimental Or Investigative Services

Experimental or investigative services or supplies. This plan also does not cover any complications or effects of such non-covered services.

Family Members Or Volunteers

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

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

Governmental Facilities

This plan does not cover services provided by a non-contracting state or federal facility that are not emergency care unless required by law or regulation.

Hair Loss

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

Hearing Exams

This plan does not cover 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.

Illegal Acts and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt.

Laser Therapy

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

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. 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

Institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered services. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes, camps and adult family homes.

Orthodontia

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

Orthognathic Surgery

Procedures to lengthen or shorten the jaw (orthognathic surgery), regardless of the origin of the condition that makes the procedure necessary.

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.

Recreational, Camp And Activity Programs

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
- Hiking, tall ship, and other adventure programs and camps
- Boot camp programs and outward-bound 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.

Services or Supplies 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.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment, including drugs, medications, or penile or other implants.

Vision Exams

This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.

Vision Hardware

This plan does not cover vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies, not covered under the **Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies** benefit. This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

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

Voluntary Support Groups

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

Weight Loss Surgery or Drugs

This plan does not cover surgery, drugs or supplements for weight loss or weight control.

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 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
 - 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:

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
 - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. If the parent who is responsible has no health coverage for the dependent, but that parent's spouse

does, that spouse's plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.

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

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

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

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

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

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

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 homeowners' coverage or commercial liability coverage
- Any type of excess coverage

• **Work-Related Illness Or Injury**

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

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

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

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to

use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

Reimbursement and Subrogation Rights

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

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

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

Your Responsibilities

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

Claims for your injury shall not be paid until Premera Blue Cross receives a completed copy of the Incident Questionnaire when one was sent.

- You must tell Premera Blue Cross if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

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

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

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

WHO IS ELIGIBLE FOR COVERAGE?

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

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

SUBSCRIBER ELIGIBILITY

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

- The employee must be a regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group’s payroll system and reported by the Group for Social Security purposes. The employee must also:
 - Regularly work a minimum of 30 hours per week
 - Satisfy a probationary period, if one is required by the Group

Employees Performing Employment Services In Hawaii

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

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated. (“Lawful spouse” means a legal union of two persons that was validly formed in any jurisdiction.
- The domestic partner of the subscriber. Domestic partnerships that are **not** documented in a state domestic partnership registry must meet all requirements as stated in the signed “Affidavit of Domestic Partnership.” All rights, benefits and obligations afforded to a “spouse” under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term “establishment of the domestic partnership” shall be used in place of “marriage”; the term “termination of the domestic partnership” shall be used in place of “legal separation” and “divorce.”
- An eligible dependent child who is under 26 years of age
An eligible child is one of the following:
 - A natural offspring of either or both the subscriber or spouse
 - A legally adopted child of either or both the subscriber or spouse

- A child placed with the subscriber for the purpose of legal adoption in accordance with state law. “Placed” for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
- A legally placed ward or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

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

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

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

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

Dependents Through Marriage After The Subscriber's Effective Date

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

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

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

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

Adoptive Children On Or After The Subscriber's Effective Date

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

Foster Children

To enroll a new foster child, we must get any payment needed, a completed enrollment form, and a copy of the child's foster papers. We must get these items no more than 60 days after the date the subscriber became the

child's foster parent. When we get these items on time, the plan will cover the child as of the date the subscriber became the child's foster parent. If we do not get the items on time, the child must wait for the Group's next open enrollment period to be enrolled.

Children Through Legal Guardianship

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

Children Covered Under Medical Child Support Orders

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

SPECIAL ENROLLMENT

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

Involuntary Loss of Other Coverage

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

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

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

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

Subscriber And Dependent Special Enrollment

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

State Medical Assistance and Children's Health Insurance Program

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

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

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

OPEN ENROLLMENT

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

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

CHANGES IN COVERAGE

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

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

PLAN TRANSFERS

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

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

- Out-of-pocket maximum
- Calendar year deductible. Please note: We will credit expenses applied to your prior plan's calendar year deductible **only** when they were incurred in the current calendar year. Expenses incurred during October through December of the prior year are not credited toward this plan's calendar year deductible for the current year.

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

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when:
 - The next required monthly charge for coverage isn't paid when due or within the grace period
 - The subscriber dies or is otherwise no longer eligible as a subscriber
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber

- For a child when he or she cannot meet the requirements for dependent coverage shown under the ***Who Is Eligible For Coverage?*** section.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

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

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes the Group with a Request for Certification of Handicapped Dependent form. The Group must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

LEAVE OF ABSENCE

Family and Medical Leave Act

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

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

“Covered member of the armed forces” also means a veteran who was discharged from the armed forces (other than a dishonorable discharge) at any time during the 5 years before the FMLA leave starts.

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

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

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

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

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

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

Other Leaves of Absence

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

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

LABOR DISPUTE

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

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

COBRA

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

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

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

Qualifying Events And Length Of Coverage

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

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

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

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

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

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

Conditions Of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

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

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

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

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

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

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

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

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

You Must Enroll And Pay On Time

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

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

- You must send your first payment to the Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly payments must also be paid to the Group.

Adding Family Members

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

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

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

If You Have Questions

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

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

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than as described under ***Intentionally False Or Misleading Statements***.

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

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

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

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

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

CONTINUATION UNDER USERRA

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

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

MEDICARE SUPPLEMENT COVERAGE

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

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

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

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

You'll need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

If you need a supply of prescription drug claim forms, contact our Customer Service department at the numbers shown on the back cover of this booklet.

Timely Filing

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

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

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

Special Notice About Claims Procedure

We'll make every effort to process your claims as quickly as possible. We process claims in the order in which we receive them. We'll tell you if this plan won't cover all or part of the claim no later than 30 days after we first receive it. This notice will be in writing. We can extend the time limit by up to 15 days if it's decided that more time

is needed due to matters beyond our control. We'll let you know before the 30-day time limit ends if we need more time. If we need more information from you or your provider in order to decide your claim, we'll ask for that information in our notice and allow you or your provider at least 45 days to send us the information. In such cases, the time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information we need, we have 15 days to give you our decision.

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

- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information 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.
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 or 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.

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 Premera Blue Cross and the Group are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.

Intentionally False Or Misleading Statements

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

WHAT ARE MY RIGHTS UNDER ERISA?

This plan is an employee welfare benefit plan that's 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.

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

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

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. 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.

Health Care Benefit Managers

Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.

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.

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member-initiated care from a remote location (ex. Home) with a provider that is diagnostic and treatment focused. The member is not located at a healthcare site.

We, Us and Our

Means Premera Blue Cross.

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To:	Contact the Pharmacy Benefit Manager At
Express Scripts	1-800-391-9701
ATTN: Commercial Claims	www.express-scripts.com
P.O. Box 14711	
Lexington, KY 40512-4711	

Customer Service

Mailing Address

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

Physical Address

3900 East Sprague
Spokane, WA 99202-4895

Phone Numbers

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

Local and toll-free TTY number:
711

Care Management

Prior Authorization And Emergency Notification

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

Local and toll-free number:
1-800-722-1471
Fax: 1-800-843-1114

Complaints And Appeals

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

BlueCard

1-800-810-BLUE(2583)

Website

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

Important Notice from Gesa Credit Union About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Gesa Credit Union** and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
 - 2. Gesa Credit Union has determined that the prescription drug coverages offered by Premera Blue Cross (\$5,000 HDHP and \$2,000 PPO) plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**
-

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **Gesa Credit Union** coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current **Gesa Credit Union** coverage, be aware that you and your dependents will be able to get this coverage back during open enrollment or in the case of a special enrollment opportunity.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **Gesa Credit Union** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Gesa Credit Union** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2022 – December 31, 2022
Name of Entity/Sender:	Lynn Braswell
Contact--Position/Office:	Human Resources Manager
Address:	51 Gage Blvd, Richland, WA 99352
Phone Number:	509.378.3100, Ext. 3088

GESA CREDIT UNION
HEALTH AND WELFARE
BENEFIT PLAN 501

EIN 91-0616262

51 Gage Boulevard
Richland, WA 99352-9700

Effective January 1, 2022

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SECTION 1. INTRODUCTION

This document constitutes the Gesa Credit Union Welfare Benefit Plan, effective January 1, 2022 (the “Plan”). Gesa Credit Union (“Company”) established this Plan to enable Covered Employees to obtain certain Employee welfare benefits. The welfare plans have been given a single plan number, and a single IRS Form 5500 has been made. The Plan provides benefits through several component benefit programs described as Covered Benefits.

This document and the Booklet constitute a single plan document. Although the Flexible Spending Account, the Health Savings Account, the Health Reimbursement Arrangements, the Limited Purpose Flexible Spending Account, and the Dependent Care Flexible Spending Account described in the Summary Plan Description (“SPD”) are included in this Plan, the Flexible Benefits Program, Health Savings Account, Limited Purpose Flexible Spending Account, and the Dependent Care Flexible Spending Account are not subject to the Employee Retirement Income Security Act of 1974 (“ERISA”).

The Plan is intended to be maintained for the exclusive benefit of Participants. The Company may terminate the Plan at any time and does not promise to continue the benefits described in this document.

No Covered Benefits are Grandfathered Plans.

SECTION 2. DEFINITIONS

The following terms used in the Plan shall have the following meanings.

2.1 “Affiliate” means a corporation or other business organization while it is controlled by or under common control with the Company, within the meaning of Code sections 414 and 1563. The determination of control shall be made without reference to paragraphs (a)(4) and (e)(3)(C) of Code section 1563. “Affiliate” also means any member of an affiliated service group (within the meaning of Code section 414(m)) of which the Company or any Affiliate is a member and any leasing organization (as defined in Code section 414(n)) to the extent its employees constitute leased employees with respect to the Company or any Affiliate. Notwithstanding the foregoing, “Affiliate” also means any entity that, pursuant to Code section 414(o) and the regulations thereunder, must be aggregated with the Company or any other Affiliate.

2.2 “Booklet” means the following document is incorporated into this Plan by this reference, as amended from time-to-time, for self-insured plans, the SPD, or other document describing the relevant Covered Benefit.

2.3 “Code” means the Internal Revenue Code of 1986, as amended, including all regulations promulgated pursuant thereto.

2.4 “Claims Administrator” means any person or persons appointed by the Plan Administrator to provide claims administration services for the Plan.

2.5 “COBRA” means the provisions requiring the continuation of employer sponsored group health coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 and set forth in Code Section 4980B, as amended, and including all regulations promulgated pursuant thereto.

2.6 “Compensation” means the total cash remuneration received by the Participant from an Employer during a Coverage Period (as reported in Box 1 of Form W-2) before any reductions pursuant to a Salary Redirection Agreement authorized under the Plan. For purposes of calculating benefits under a specific Covered Benefit, a different definition of “Compensation” may be set forth in the Booklet, which shall be controlling for such purpose.

2.7 “Coverage Period” means the calendar year for this Plan and for each Covered Benefit, the period or Plan Year as outlined in the Booklet for such Covered Benefit.

2.8 “Covered Benefits” means for Covered Employees and their Covered Dependents, the benefits described in Exhibit A.

2.9 “Covered Dependent” means a Dependent whose coverage under the terms of the Booklet for a Covered Benefit has become effective and has not terminated in accordance with those terms. The term “Covered Dependent” shall also include a Dependent who has elected COBRA continuation of a Covered Benefit.

2.10 “Covered Employee” means an Eligible Employee whose coverage under the terms of the Booklet for a Covered Benefit has become effective and has not terminated in accordance with those terms. The term “Covered Employee” shall also include an Employee who has elected COBRA continuation of a Covered Benefit under the Plan.

2.11 “Dependent” means a dependent of an Eligible Employee as defined in the Booklet for the relevant Covered Benefit. In addition, the definition of “Dependent” shall include any person required to be covered under the Plan as a Dependent of an Eligible Employee as required by any applicable state or federal law.

2.12 “Domestic Partner” means a person who meets and continues to meet all the criteria detailed in the Spouse/Domestic Partner Affidavit, provided that a properly completed Spouse/Domestic Partner Affidavit and proof of registration of domestic partnership in accordance with state or local law has been filed with the Employer. The term Domestic Partner shall also include a civil union as defined under the laws of a state that recognizes a civil union if proof of the civil union has been filed with the Employer. A Domestic Partner may participate in a Covered Benefit only if permitted by the Booklet.

2.13 “Election Period” means the period immediately preceding each Coverage Period that is designated by the Plan Administrator or the relevant Booklet for the election of Covered Benefits.

2.14 “Eligible Employee” means an individual who meets the eligibility requirements for a Covered Benefit as described in the Booklet for that benefit.

The term “Eligible Employee” does not include nonresident aliens, leased Employees, Employees covered by a collective bargaining agreement where welfare benefits were the subject of good faith bargaining that does not provide for participation in the Plan, or individuals determined by the Employer (in its sole discretion) to be contract Employees, independent contractors, temporary Employees or any other nonregular Employee.

Notwithstanding the foregoing, an individual who is not treated by the Employer as an Employee for payroll tax purposes, but who is subsequently determined by a government agency, the conclusion or settlement of threatened or pending litigation, or otherwise, to be (or to have been) a common law employee of the Employer shall not be an Eligible Employee, unless and until (and only to the extent) the Plan Administrator provides otherwise.

2.15 “Employee” means an individual classified by an Employer as an Employee of the Employer, as evidenced by the Employer’s withholding of federal income and employment taxes from such individual’s Compensation. If, during any period, that Employer has not classified that individual as an Employee, then that individual will not be an Employee for that period, even if the individual is subsequently determined by that Employer, by a governmental agency, the conclusion or settlement of threatened or pending litigation, or otherwise, to have been a common law employee of that Employer. In accordance with the terms of the Booklet for a Covered Benefit, a former employee may be considered an “Employee” or “Eligible Employee.” The term “Employee” shall not mean an independent contractor.

2.16 “Employer” means Gesa Credit Union and any Affiliate that, with the approval of the Company and the approval of such Affiliate, has elected or elects to adopt the Plan. The Employer agrees to be bound by such terms and conditions relating to the Plan as the Company may reasonably require.

2.17 “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time, and including all regulations promulgated pursuant thereto.

2.18 “Grandfathered Plan” means a group health plan (or benefits package made available thereunder) in existence on March 23, 2010, that is “grandfathered” under section 1251 of the Patient Protection and Affordable Care Act, Treasury Regulation §54.9815-1251T and subsequent guidance.

2.19 “Health Care Reform Law” means the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, and including all regulations promulgated pursuant thereto.

2.20 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended, and all regulations promulgated pursuant thereto.

2.21 “Participant” means a Covered Employee and/or a Covered Dependent.

2.22 “Plan” means the Gesa Credit Union Welfare Plan, as set forth in this document and amended from time-to-time.

2.23 “Plan Administrator” means Administrative Committee with respect to this Plan. The Booklet for a Covered Benefit may have a separate plan administrator or claims administrator.

2.24 “Plan Election Form” means the paper or electronic election submitted by an Eligible Employee with the Employer by the election procedures for the Covered Benefit.

2.25 “Plan Year” means the 12-consecutive-month period commencing on January 1 of each year.

2.26 “Salary Redirection Agreement” means an agreement between a Covered Employee and an Employer under which the Covered Employee agrees to reduce their Compensation or to forgo increases in such Compensation and to have such amounts contributed by the Employer for a Covered Benefit on the Covered Employee’s behalf. The agreement shall apply only to Compensation that has not been actually or constructively received by the Covered Employee as of the date of the agreement (after taking the Covered Benefit and Code section 125 into account) and subsequently does not become currently available to the Participant.

2.27 “SPD” shall mean the ‘Summary Plan Description’ required under ERISA with respect to a Covered Benefit.

2.28 “Spouse” means: (a) for insured Covered Benefits, an Eligible Employee’s spouse as defined in the Booklet; and (b) for self-insured Covered Benefits, a Spouse under federal law. For purposes of federal law, Spouse means an individual (including an individual of the same gender) who is married under the laws of a state or the laws of a domestic or foreign jurisdiction having the legal authority to sanction such marriage. In determining the legality of a marriage, the law of the place of celebration shall control.

**SECTION 3.
ELIGIBILITY
AND
PARTICIPATION**

3.1 Eligibility and Participation

An Employee who meets the eligibility requirements (i.e., for the majority of benefits offered working a minimum of 30 hours per week, under ACA rules) for a Covered Benefit and who completes any required election or enrollment form for such Covered Benefit shall participate in such Covered Benefit in accordance with the terms of the Booklet governing such Covered Benefit. Employee contributions can be in the enrollment system and annual open enrollment communications.

3.2 Change in Employment Status and Rehired Eligible Employees

If a former Covered Employee ceases to be an Eligible Employee and again becomes an Eligible Employee, they shall resume participation in the Covered Benefit in accordance with the terms of the Booklet for such Covered Benefits.

3.3 Change or Revocation of Plan Election Form and Salary Redirection Agreement

An Eligible Employee may change or revoke a Covered Benefit, election form, or Salary Redirection Agreement only as permitted in the Booklet for the Covered Benefit and for Covered Benefits that are paid for on a pretax basis under the Gesa Credit Union Flexible Benefits Program in accordance with Treasury Regulation Section 1.125-4.

3.4 Special Enrollment

(a) Loss of Other Coverage.

An Eligible Employee who declined to participate or to enroll a Dependent in a Covered Benefit that is a health coverage option (“Health Coverage”) during the Election Period due to other health insurance coverage may elect to enroll in health coverage under the Plan upon loss of the other health coverage. In the case, the other coverage was COBRA continuation coverage, the loss must result from the exhaustion of that COBRA coverage, or if the other coverage was not COBRA coverage, either the coverage must be terminated as a result of loss of eligibility for the coverage or Employer contributions toward the coverage must be terminated. The term “loss of eligibility” includes a loss of coverage because of legal separation, divorce, termination of employment, or reduction in hours of employment but does not include any loss due to failure to pay premiums on a timely basis or termination of coverage for cause. Enrollment application must be made after the loss of the other coverage within the time period established by the Booklet for the Covered Benefit. Gesa Credit Union may require proof of loss of coverage. Enrollment is effective in accordance with

the Booklet for the Covered Benefit.

(b) New Dependents.

An Eligible Employee who declined to enroll in health coverage during a previous enrollment period might enroll in health coverage if they acquired a Dependent through marriage, birth, adoption, or placement for adoption. To enroll in a Covered Benefit that is health coverage, the Eligible Employee must submit a qualifying life event through the current Employee Self Service system and complete enrollment and election form(s), as required by the Booklet for that health coverage within 60 days.

A Participant who acquires a Dependent through marriage, birth, adoption, or placement for adoption may enroll an eligible Dependent in health coverage by submitting a qualifying life event through the current Employee Self Service system and completing any enrollment or election form(s) required by the Booklet for the Covered Benefit within 60 days.

In the case of marriage, birth, adoption, or placement for adoption, health coverage enrollment is effective on the date of such marriage, birth, adoption, or placement for adoption, in accordance with the provisions of the Booklet for the Covered Benefit.

(c) CHIPRA Special Enrollment.

An Eligible Employee, or their Dependent(s), who are not enrolled in health coverage may enroll for coverage in accordance with the provisions of the Booklet for the Covered Benefit if such Eligible Employee or their Dependent:

(i) Is covered under a Medicaid plan under title XIX of the Social Security Act, or under a State, child health plan under title XXI of such Act, and coverage of the Eligible Employee or their Dependent is terminated as a result of loss of eligibility for such coverage, provided that the Employee requests within the time period established by the Booklet for the Covered Benefit; or

(ii) Becomes eligible for assistance concerning Health Coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act (including under any waiver or demonstration project conducted under or in relation to such a plan), provided that the Employee requests coverage within the time period established by the Booklet for the Covered Benefit.

3.5 Termination of Covered Employee and Dependent Participation

A Covered Employee's or Dependent's Plan participation shall terminate in accordance with the provisions of the Booklet for the Covered Benefit.

3.6 Leave(s) of Absence

Covered Benefits for an Employee or a Dependent shall continue during a leave of absence only in accordance with the governing Booklet. In addition, contributions, benefits, and participation under the Plan with respect to Employees who are performing qualified military service will be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

3.7 Participation Restrictions

The following participation restrictions apply:

(a) A Participant may not participate simultaneously in a Covered Benefit as an Eligible Employee and a Dependent.

(b) Except as required under Section 10 (COBRA), a Dependent may be enrolled in the Plan only if the Eligible Employee also enrolls in the Plan.

3.8 Rescission of Coverage

To the extent required by applicable law, a Participant's coverage under a Covered Benefit that is a group health plan as defined in the Code shall not be rescinded as described in Treasury Regulation §54.9815-2712T unless the Participant (or a person seeking coverage on behalf of the Participant) performs an act, practice or omission that constitutes fraud or unless the Participant makes an intentional misrepresentation of material fact. Each Participant whose coverage under a Covered Benefit is rescinded under this Section 3.8 shall be provided with at least 30 days advance written notice of such rescission.

SECTION 4. COST

4.1 Cost of Benefits

The Employer shall make certain Covered Benefits available to each Participant as determined by the Employer, in its sole discretion, and communicated to the Participants. Each year the Employer shall review the costs of the Covered Benefits and determine its and the Participants' share of those costs (including the costs applicable during a leave of absence).

4.2 Notification of Cost of Covered Benefits

The Employer shall notify each Employee of the cost of covered benefits during the annual Open Enrollment election, and costs are openly posted and communicated to Employees throughout the plan year. Before submitting their election or enrollment forms during an Election Period, all Participants shall be notified of the Covered Benefits under

the Plan and the associated Participant cost.

SECTION 5. COVERED BENEFITS

5.1 Covered Benefits

(a) The Covered Benefits provided under the Plan are outlined in Exhibit A. The Employer is under no obligation to offer any specific Covered Benefit and may change or terminate any Covered Benefit at any time, including, without limitation, the cost-sharing between the Employer and the Participant. Exhibit A may be amended and replaced periodically by the Plan Administrator to update the references to Covered Benefits, as necessary.

(b) The terms of the Covered Benefits are outlined in the Booklet, and in case of a conflict between a Booklet and this Plan, that Booklet will control. The insurer, contract number, or funding method of providing the Covered Benefits may change from time-to-time.

(c) No Covered Benefit shall be paid, or expense reimbursed, for any Plan Year unless the Participant applies for such benefit or reimbursement within the time limits described in the Booklet.

5.2 No Assignment of Benefits

(a) Except for the payment of claims permissible under the terms of the Booklet for the Covered Benefit, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge of any kind, and any attempt to affect the same shall be void.

SECTION 6. CLAIM DETERMINATION AND APPEAL PROCEDURES

The Booklet shall establish a claims procedure for the Plan in accordance with ERISA Section 503 and regulations thereunder prescribed by the Secretary of Labor. The Claims Administrator, designated in the Booklet, shall have discretionary authority to determine any issue of fact or law for a Covered Benefit. Such procedures shall be set forth in the SPD for the Plan, which is hereby incorporated by reference. The decision on review concerning an appeal under said claims procedures shall be final, binding, and conclusive on the Employer, the Plan, the Participant, and all persons affected thereby. Absent an abuse of discretion, the Claims Administrator's decision must be upheld by a Court of Law. To the extent that any Covered Benefits do not constitute a Grandfathered Plan or do not constitute a separate benefits package not subject to Health Care Reform, in addition to the aforementioned claims and appeal procedures, the Booklet shall comply

with the requirements of Health Care Reform Law concerning internal and external review procedures.

SECTION 7. HIPAA INFORMATION

7.1 HIPAA Privacy Rule

The Employer shall comply with the plan document requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) privacy regulations (“Privacy Rule”) found in 45 CFR Section 164.504(f)(2).

(a) Covered Plans

(i) This Section 7.1 of the Plan applies only to health-related benefits such as medical, dental, vision, behavioral and mental health, employee assistance program, and health care reimbursements from the health reimbursement account, health care spending, or limited purpose account under the Flexible Benefits Program.

(ii) The HIPAA Privacy Rule and this Section 7.1 do not apply to disability plans (long-term and short-term disability), life insurance plans, including accidental death and dismemberment, dependent care expense reimbursements, Workers’ Compensation, and property and casualty insurance.

(b) Permitted and Required Uses of Protected Health Information

The Employer shall use or disclose personal medical information, Protected Health Information (“PHI”), it receives from the Plan as permitted or required by, and consistent with 45 CFR Part 164, Subpart A, specifically for purposes related to Plan administration, such as health care treatment, payment for health care, and health care operations.

(c) Certification

The Plan shall disclose Protected Health Information (“PHI”) to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to incorporate all the required provisions found in 45 CFR Section 164.504(f)(2)(ii)(A) - (J), as set forth in Section 7.1(d) below.

(d) Agreement

Employer agrees to:

(i) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents and as required by law;

(ii) Ensure that any agents to whom it gives PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information;

(iii) Not use or disclose the PHI for employment-related actions or in connection with any other benefit or employee benefit plan of the Employer, unless that use, or disclosure is permitted or required by law;

(iv) Report to the Plan Administrator any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware;

(v) Make available PHI in accordance with individuals' rights to access and inspect their Protected Health Information, pursuant to 45 CFR 164.524;

(vi) Make available PHI for amendment and incorporate any amendments to Protected Health Information consistent with 45 CFR 164.526;

(vii) Make available the information required to provide an accounting of disclosures to individuals, in accordance with 45 CFR 164.528;

(viii) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule; and

(ix) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form. The Employer will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if such return or destruction is not feasible. Still, the Plan must limit further uses and disclosures to those purposes that make the return or destruction of the Protected Health Information infeasible.

(e) Separation of Employer and the Plan

The following Employees or classes of employees involved in the day-to-day administration of a Covered Benefit have access to Protected Health Information: Lynn Braswell, Human Resources Manager; Lindsey Evensen, Sr. Rewards and Relations Partner; Leah Laughery, Rewards and Relations Partner; and Kindra Cobos, Rewards and Relations Partner.

(f) Restriction of Access to and Use of Protected Health Information

The Employer shall restrict the access to, and use of Protected Health

Information (“PHI”) by the Employees and other required persons described in Section 7.1(e) above to the Plan administration functions that the Employer performs for the Plan, including health care treatment, payment for health care, and health care operations.

(g) Mechanism to Resolve Issues of Noncompliance

The sanctions provision of the privacy policies of the Employer will be used to resolve any issues of noncompliance by Employees or persons described in Section 7.1(e) above.

7.2 HIPAA Security Rule

The Employer shall comply with the plan document requirements of the HIPAA security regulations found at 45 CFR Section 164.314(b) as follows:

(a) Electronic Protected Health Information

Electronic Protected Health Information (“ePHI”) shall mean individually identifiable health information transmitted by electronic media or maintained in electronic media by the Plan.

(b) Agreement

The Employer agrees to:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

(ii) Ensure that the adequate separation between the Plan and the Employer as required by the Privacy Rule is supported by reasonable and appropriate security measures;

(iii) Ensure that any agent to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and

(iv) Report to the Plan Administrator any security incident of which it becomes aware.

SECTION 8. ADMINISTRATION

8.1 Plan Administrator

The Plan Administrator is responsible for the general administration and management of the Plan.

8.2 Administrative Powers and Duties of Plan Administrator

The Plan Administrator shall have full power, discretion, and authority to administer the Plan and to construe and apply all its provisions in a non-discriminatory manner for the exclusive benefit of Participants and their beneficiaries. The Plan Administrator shall have all powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Plan and the facts and circumstances of claims for benefits. The Plan Administrator's powers and duties, unless properly delegated, shall include, but shall not be limited to:

- (a) Making and enforcing such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) Designating agents to carry out responsibilities related to the Plan other than fiduciary responsibilities;
- (c) Interpreting the provisions of the Plan and determining any question arising under the Plan or in connection with the administration or operation thereof, including, without limitation, deciding questions relating to eligibility and amounts of benefits;
- (d) Deciding disputes that may arise regarding the rights of Employees, former Employees, Dependents, and Participants (or any of their legal representatives) under the terms of the Plan;
- (e) Obtaining information from the Employer with respect to the Participants as necessary to determine the rights and benefits of the Participants under the Plan. The Plan Administrator may rely conclusively on such information furnished by the Employer;
- (f) Compiling and maintaining all Plan records it deems necessary for the administration of the Plan;
- (g) Authorizing payment of all benefits as they become payable under the Plan;
- (h) Engaging such legal, administrative, consulting, actuarial, investment, accounting, and other professional services as the Plan Administrator deems proper;

- (i) Adopting rules and regulations for the administration of the Plan that are not inconsistent with applicable law. In a nondiscriminatory manner, the Plan Administrator may waive the timing requirements of any notice or other requirements described in the Plan. Any such waiver will not obligate the Plan Administrator to waive any subsequent timing or other requirements for other Participants;
- (j) Developing and implementing procedures for examining, evaluating, determining, and litigating the qualification of medical support orders; and interpreting, approving, and administering qualified medical support orders in compliance with relevant laws and the provisions of the Plan; and
- (k) Performing other actions provided for in other parts of this Plan.

8.3 Conclusiveness of Action

Any action on matters within the Plan Administrator's discretion will be conclusive, final, and binding upon all Participants and upon all persons claiming any rights under the Plan.

8.4 Payment of Expenses

All costs of administering the Plan (including the cost of legal or advisory services) will be paid from the Plan's assets to the extent permissible under applicable law unless the Employer, in its discretion, elects to pay for such expense.

8.5 Compensation

The Plan Administrator and any delegate compensated as an Employee by the Employer will not receive compensation from the Plan for services to the Plan.

8.6 Forms

All elections and other communications (including telephonic, written, and electronic versions) from any Participant or other person to the Plan Administrator required or permitted under the Plan shall be in the form prescribed from time to time by the Plan Administrator or the Booklet, shall be mailed by first-class mail or delivered (including delivery by facsimile transmission, telex, telegram, inter-office mail, or online) to the location specified by the Plan Administrator, and shall be deemed to have been given and delivered only upon actual receipt thereof. Each Participant shall file such pertinent information as the Plan Administrator may specify via a Plan Election Form.

8.7 Examination of Documents

The Plan Administrator shall make available to each Participant such documents and records as pertain to the Participant for examination at reasonable times during regular business hours. In addition, all Plan Documents are posted to the intranet for Employee reference.

8.8 No Assets

Except as required explicitly to the contrary under the terms and conditions of one or more Employer-sponsored trusts, no assets shall be segregated to provide benefits under the Plan, and all uses shall be payable solely from the Employer's general assets. A Participant has only an unsecured contract right to receive payments under the terms of the Plan. Any contributions are held by the Employer and remain available to the Employer's general creditors. Participant accounts are a recordkeeping device, and any funds in such accounts are general assets of the Employer. No interest shall be credited to any Participant's account. Amounts withheld from Employees are treated as general assets of the Employer on a pre-tax basis.

8.9 Reports

The Plan Administrator shall file or cause to be filed all annual reports, returns, and financial or other statements required by any federal or state statute, agency, or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements, or other documents to such Participants and beneficiaries as required by federal or state statute or regulation, within the time prescribed for furnishing such documents.

SECTION 9. AMENDMENT, TERMINATION, OR ADOPTION OF PLAN

9.1 Amendment of the Plan and Covered Benefits

(a) The Company and the Plan Administrator shall have the right by an instrument in writing to modify, alter or amend this Plan or any Covered Benefit in whole or in part, at any time and for any reason.

(b) The Employer and the Plan Administrator shall have the right to modify, alter or amend the cost-sharing between the Employer and a Participant at any time and for any reason.

9.2 Termination of the Plan

(a) The Plan has been established with the intention that it shall be continued in operation for an indefinite period. However, the Employer reserves the right to terminate its participation in the Plan, and the Company and the Plan Administrator reserve the right at any time to terminate or partially terminate this Plan, or the Booklet for any Covered Benefit, in writing, at any time and for any reason. No rights are vested under the Plans offered.

(b) Should the Company or the Plan Administrator decide to terminate or partially terminate the Plan, the Employer shall proceed to take such steps as are necessary to discontinue the operation of the Plan in an appropriate and timely manner.

SECTION 10. COBRA CONTINUATION OF COVERAGE

10.1 Continuation of Coverage

Each Covered Benefit, a group health plan defined in Code Section 5000(b)(1), contains continuation coverage provisions complying with COBRA. Such provisions for COBRA continuation coverage as set forth in the Booklet are incorporated herein by reference. Notwithstanding anything in this Plan to the contrary, to the extent required by COBRA and the Final and Proposed Treasury Regulations thereunder, a Qualified Beneficiary who would lose coverage under the Plan upon the occurrence of a Qualifying Event shall be permitted to continue group health plan coverage under this Plan, in accordance with procedures established by the Plan Administrator.

10.2 COBRA Definitions

For purposes of COBRA continuation coverage as described in this Section 10, the following words or phrases shall have the meaning set forth below unless the contrary is clearly indicated:

(a) Covered Employee. The term “Covered Employee” means any Eligible Employee who is (or was) a Covered Employee on the date of a Qualifying Event.

(b) Qualified Beneficiary

(i) The term “Qualified Beneficiary” means, with respect to any Covered Employee, any other individual who, on the day before the Qualifying Event for that Covered Employee, is covered under the Plan as the (1) Spouse of the Covered Employee; (2) Domestic Partner of the Covered Employee; or (3) Dependent child of the Covered Employee or the Covered Employee’s Domestic Partner. A child born to or placed for adoption with a Covered Employee during the period the Covered Employee has elected continuation coverage is also a Qualified Beneficiary.

(ii) When the Qualifying Event is the reduction of hours or termination of the Covered Employee’s employment, the term “Qualified Beneficiary” shall include the Covered Employee.

(iii) In the case when the Qualifying Event is the commencement of a bankruptcy proceeding under Title 11 of the United States Code, with respect to the Employer from whose employment the Covered Employee retired, the term “Qualified Beneficiary” shall include

a Covered Employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such Qualifying Event, is covered under the Plan as the (1) Spouse of the Covered Employee; (2) Domestic Partner of the Covered Employee; (3) Dependent Child of the Covered Employee or the Covered Employee's Domestic Partner; or (4) surviving Spouse or Domestic Partner of the Covered Employee.

(c) Qualifying Event:

The term "Qualifying Event" means, with respect to any Covered Employee, any of the following events which would result in the loss of coverage under the Plan of a Qualified Beneficiary, but for the continuation coverage required under this Section 10:

- (i) The death of the Covered Employee;
- (ii) The reduction of hours or termination (other than because of the Covered Employee's gross misconduct) of the Covered Employee's employment;
- (iii) The divorce of the Covered Employee from the Covered Employee's Spouse;
- (iv) The termination of a domestic partnership between the Covered Employee and their Domestic Partner;
- (v) The Covered Employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act;
- (vi) A Dependent child of the Covered Employee or of the Covered Employee's Domestic Partner ceasing to be a Dependent under the generally applicable requirements of the Plan; or
- (vii) Commencement of a bankruptcy proceeding under Title 11 of the United States Code with respect to the Employer from whose employment a Covered Employee retired at any time.

10.3 Election of COBRA Coverage

A Qualified Beneficiary must elect COBRA coverage within the election period. The election period shall be 60 days beginning not later than the date on which the Qualified Beneficiary's coverage under the Plan would terminate because of a Qualifying Event and ending 60 days after the later of such date or the date the Qualified Beneficiary is notified of their rights under this Section concerning the Qualifying Event, except that a Qualified Beneficiary who becomes a federal Trade Act of 2002 eligible individual may elect COBRA coverage within the election period beginning on the date on which the Qualified Beneficiary first becomes such an eligible individual, but no later

than six (6) months following their Qualifying Event. Coverage under the Plan will terminate at the end of the calendar month during which the Qualifying Event occurs and then will be reinstated retroactively if the Qualifying Beneficiary elects COBRA coverage during the election period.

10.4 Cost and Payment for COBRA Coverage

The cost of COBRA coverage shall be paid for by (or on behalf of) the Qualified Beneficiary who elects such coverage. The cost of COBRA coverage is 102% of the total cost of Plan coverage. The payment of any premium due shall be timely if made within 30 days after its due date; provided, however, that payment for continuation coverage during the period preceding the election shall be timely if made within 45 days of the date of the election.

10.5 Termination of COBRA Coverage

Once elected, COBRA coverage will continue until the earliest of the following:

The last day of the maximum COBRA coverage period outlined in Code Section 4980B(f)(2)(B)(i); or

- (a) The date the Plan is terminated; or
- (b) The date on which the Qualified Beneficiary fails to make timely premium payments for continuation coverage; or
- (c) The date on which the Qualified Beneficiary first becomes covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary; or
- (d) The date the Qualified Beneficiary first becomes entitled to Medicare coverage. (Medicare entitlement terminates continuation coverage only for the Medicare-entitled individual.)

10.6 COBRA Notice Requirements

The Employer's COBRA Plan Administrator shall provide written notice to each Covered Employee and their Covered Dependents (if any) of the rights provided under this Section 10 at such times as required by COBRA or as described in the Booklet.

10.7 Plan Changes

In the case, during a period of COBRA coverage, as set forth above, this Plan coverage is changed for Eligible Employees, the same changes will be applied to similarly situated persons participating in the Plan pursuant to this Section 10.

10.8 Changes in Applicable Law

If applicable law subsequently requires that COBRA coverage be extended, financed, or offered differently than specified in this Plan, the Plan shall be deemed amended to comply with the minimum requirements of applicable law and shall be administered in accordance thereof. This provision is not intended to implement changes in applicable law any earlier than the latest date required by such law.

10.9 Continuation of Coverage Under Family and Medical Leave Act (FMLA)

(a) Notwithstanding anything in the Plan to the contrary, to the extent required under FMLA and the regulations thereunder, a Covered Employee on leave under FMLA may choose to continue coverage under the Plan by making applicable contributions in the following modes as permitted under the rules established by the Plan Administrator and in compliance with FMLA regulations:

- (i) By payroll deduction during the leave, if the Covered Employee is paid Compensation during the leave;
- (ii) By prepaying any contributions prior to the commencement of the FMLA leave on a pre-tax or after-tax basis;
- (iii) By continuing to pay timely on an after-tax basis all required contributions during the term of the FMLA leave; or
- (iv) When the Covered Employee returns to work if the Covered Employee is not paid compensation or has insufficient compensation to pay for coverage under the Plan during the leave and the Employer and Covered Employee have agreed in advance of the FMLA leave that the Employer shall recoup contributions upon the Covered Employee's return to work.

(b) A Covered Employee on FMLA leave may also revoke an existing election for the remainder of the Coverage Period (i.e., to the end of the Plan Year) or elect to be reinstated upon return from FMLA leave established by the Plan Administrator and in compliance with FMLA.

(c) Where FMLA leave spans two Plan Years, a Covered Employee on FMLA leave may only make a coverage election for the remainder of the Plan Year in which the FMLA leave begins.

SECTION 11. MISCELLANEOUS

11.1 Plan Interpretation.

This document and all appendices and amendments set forth the provisions of the Plan. The Plan shall be read in its entirety and not severed except as provided in Section 11.2.

11.2 Severability.

In the case, any provision of the Plan is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of the Plan, which shall be construed as if the illegal or invalid provisions had never been included.

11.3 Payments

In the case, any amount becomes payable under the Plan to a minor or a person who, in the sole judgment of the Plan Administrator, is unable to give a valid receipt for the payment by reason of physical or mental condition, the Plan Administrator may direct that such payment be made to any person found by the Plan Administrator, in its sole judgment, to have assumed the care of the person in question. Any payment made pursuant to such determination shall constitute a full release and discharge of the Plan, the Plan Administrator and the relevant Employer, and their respective officers, directors, employees, agents, and representatives.

11.4 Consolidation or Merger

In the event of the consolidation or merger of the Company with or into any other business entity or the sale by the Company of its assets, the successor may continue the Plan by adopting it. If, effective as of the closing date of a sale of assets, a successor corporation, partnership, or proprietorship does not adopt the Plan; the Plan will be deemed terminated.

11.5 Limitation on Rights

The Plan is strictly a voluntary undertaking on the part of the Employer. It does not constitute a contract between an Employer and any person, or consideration for, or an inducement or condition of, the employment of a person. Nothing contained in the Plan will give any person the right to be retained in the service of an Employer or to interfere with or restrict the right of the Employer, which is hereby expressly reserved, to discharge any person or alter the terms and conditions of employment at any time, with or without cause or notice. Inclusion under the Plan will not give any person any right or

Claim to any Covered Benefit hereunder except to the extent such right has specifically become fixed under the terms of the Plan. A Participant or Eligible Employee shall have no vested right in any Covered Benefit or the cost of obtaining such Covered Benefit.

11.6 No Property Rights

No one has any right, title, or interest in specific property of an Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to them.

11.7 Governing Law

The Plan will be interpreted, administered, and enforced in accordance with ERISA, to the extent applicable, and the Code to the extent applicable to the Covered Benefits provided under the Plan, and the rights of Participants, former Participants, their beneficiaries, and all other persons will be determined in accordance therewith. To the extent that state law is applicable, the laws of the State of Washington shall apply. Notwithstanding the foregoing, nothing under state law shall be interpreted as restricting the ability of the Company to amend, modify, or terminate this Plan or any Covered Benefit or the ability of an Employer to change or modify the cost sharing under this Plan or any Covered Benefit. The Covered Benefits under this Plan are provided solely on the basis that they are not vested benefits, and such Covered Benefits may be modified, amended, or terminated by an Employer, at any time and for any reason.

11.8 Governing Instrument

This document, together with the Booklet for the Covered Benefits, constitute the Plan. In case of conflict between the Plan and any other document, the terms of the Booklet shall govern.

11.9 Captions and Headings

The captions and headings of a Section or provision of the Plan have been inserted solely for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

11.10 Notices

No notice or communication in connection with the Plan made by a claimant or a Participant shall be effective unless duly executed on a form provided or approved by, and filed with, the Plan Administrator (or the representative of the Plan Administrator) unless made in compliance with an alternate procedure expressly specified in the Booklet. All notices, statements, reports, and other communications from an Employer to any Employee or other person required or permitted under the Plan shall be deemed to have been duly given when delivered to (including delivery by facsimile transmission, telex, telegram, inter-office mail, or online), or when mailed by first-class mail, postage prepaid, and addressed to, such Employee or other person at their address last appearing on the Employer's personnel records and/or within the Employer's Human Resources Information System. It is the Employee's responsibility to update and maintain their records.

11.11 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless explicitly stated in writing and only for the stated period. Such waiver shall operate only as to the specific term, condition, or provision waived.

11.12 No Assignability of Rights

The right of any Participant to receive any reimbursement under the Plan is not alienable by the Participant by assignment or any other method and is not subject to the claims of their creditors by any process whatsoever, and any attempt to cause such right to be so subject will not be recognized, except to the extent as may be required by law or explicitly provided for in the Plan.

11.13 No Guarantee of Tax Consequences

Neither the Employers nor the Plan Administrator make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state tax purposes or that any other federal or state tax treatment will apply to or be available to any Participant. It will be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes and to notify the Plan Administrator if the Participant has reason to believe that any such payment is not so excludable.

11.14 Indemnification

The Employer, to the maximum extent permitted by law and its governing instruments, shall indemnify and hold harmless directly from its assets (including the proceeds of any liability insurance policy, the premiums of which are paid from the Employer's assets), the Employer's board, managers, officers, fiduciary, Plan Administrator and Employees from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying their responsibilities under the Plan, unless due to the willful misconduct of such persons.

11.15 Facility of Payment

In the event any benefit under the Plan shall be payable to a person who is under legal disability or is in any way incapacitated to be unable to manage their financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian or another legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under the Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision shall fully discharge the relevant Employer and the Plan of any liability to the extent of such payment.


11.16 Correction of Errors

If an incorrect amount is paid to or on behalf of a Participant or beneficiary, any remaining payments may be adjusted to correct the error. The Plan Administrator may take such other action it deems necessary and equitable to correct any such error.

IN WITNESS WHEREOF, Gesa Credit Union has caused this Plan to be executed in its name and behalf effective as of January 1, 2022, by its officer thereunto duly authorized.

Dated: September 22, 2022

Gesa Credit Union

By: 

Title: AVP of Team Engagement

Plan Sponsor

(509) 378-3100

EXHIBIT A.
COVERED EMPLOYEE BENEFITS

Effective January 1, 2022, the following Covered Benefits are offered under the Plan, which Covered Benefits may be amended from time to time. The Booklet sets forth terms applicable to each Covered Benefit and are incorporated into this Plan and made a part of this Plan by this reference.

Eligible dependents include the Employee spouse, a domestic partner (completion of an Affidavit of Domestic Partnership is required), and children up to age 26, regardless of dependent, student, or marital status. Children may include natural, adopted, stepchildren, and children obtained through court-appointed legal guardianship, as well as children of same-sex state-registered domestic partners.

The effective date for the plan year is January 1, 2022. Newly hired full-time team members and dependents will be eligible to enroll in Gesa Credit Union's benefits programs on the first of the month following or coinciding with the date of hire of full-time employment.

1. Medical and Pharmacy
2. Dental
3. Vision
4. Basic Life and AD&D
5. Voluntary Life and AD&D
6. Short-Term Disability
7. Long-Term Disability
8. Flexible Spending Accounts
9. Health Saving Account
10. Health Reimbursement Account

Delta Dental PPOSM

Gesa Credit Union

Delta Dental of Washington

Plan Number: 09644 – Base Plan

Effective Date: January 1, 2022

Welcome to your Dental Plan, administered by Delta Dental of Washington, a founding member of the nationwide Delta Dental Plans Association.

We believe everyone can enjoy good oral and overall health, with no one left behind. It drives everything we do and has been our sole focus for over 60 years.

Your plan is a resource to make it easy for you to care for your smile. This benefit booklet summarizes your coverage and describes how your benefits may be used. Understanding your benefits is the first step to getting the most from your dental plan. Review this booklet before you visit your Dentist and keep it for your reference.

You deserve a healthy smile. We're happy to help you protect it.

Questions Regarding Your Plan

If you have questions regarding your dental benefits plan, please call or email our Customer Service Department at:

800-554-1907

CService@DeltaDentalWA.com

Written inquiries may be sent to:

Delta Dental of Washington

Customer Service Department

P.O. Box 75983

Seattle, WA 98175-0983

For the most current listing of Delta Dental Participating Dentists, visit our online directory at www.DeltaDentalWA.com or call us at 800-554-1907.

Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-Blind or Speech-Disabled

Communication with Delta Dental of Washington for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with Delta Dental of Washington through specially trained communications assistants.

Dial 711 (the statewide telephone relay number) or 800-833-6384 to connect with a Washington Relay Service communications assistant. Ask them to dial Delta Dental of Washington Customer Service at 800-554-1907. They will then relay the conversation between you and our customer service representatives.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

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Section A – Summary of Benefits

Reimbursement Levels for Allowable Benefits

In-Network – Delta Dental PPO Dentists

Class I	100%
Class II	80%
Class III	50%
Annual Deductible per Person	\$100
Annual Deductible — Family Maximum	\$300

Out-of-Network – Non-Delta Dental PPO

Class I	100%
Class II	80%
Class III	50%
Annual Deductible per Person	\$100
Annual Deductible — Family Maximum	\$300

Plan Maximum

Annual Plan Maximum per Person\$1,500

The payment level for covered dental expenses arising as a direct result of an accidental injury is 100 percent, up to the unused Plan Maximum.

All Enrolled Employees and Enrolled Dependents are eligible for Class I, Class II, Class III Covered Dental Benefits, and accidental injury benefits.

The annual deductible is waived for:

- ◇ Class I Covered Dental Benefits.
- ◇ Accidental Injury Benefits.

How to use your Plan

The best way to take full advantage of your dental Plan is to know its features. You can learn them by reading this benefit booklet before you go to the Dentist. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions. If you have questions or do not understand something, please give us a call at 800-554-1907. We're more than happy to help.

Consult your provider regarding any charges that may be your responsibility before treatment begins.

Coinsurance

DDWA will pay a percentage of the cost of your treatment and you are responsible for paying the allowable balance. The part you pay is called the coinsurance. If your plan has a deductible, you are responsible for the coinsurance even after a deductible is met.

Please see your "Reimbursement Levels for Allowable Benefits" under the "Summary of Benefits" section for details on the coinsurance required by your plan.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this Plan, the benefit period is the 12-month period starting the first day of January and ending the last day of December.

Plan Maximum

The Plan Maximum is the maximum dollar amount DDWA will pay toward the cost of dental care within a specific benefit period. The maximum amount payable for Covered Dental Benefits in each benefit period is listed in the "Summary of Benefits" section in this booklet.

Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed, also known as the seat date. Amounts paid for such procedures will be applied to the Plan Maximum based on the incurred date.

Plan Deductible

Your Plan has a deductible, which can be found in the "Summary of Benefits" section. This means that from the first payment or payments DDWA makes for Covered Dental Benefits, a deduction is taken. This deduction is owed to the provider by you. Once an Enrolled Person has satisfied the deductible during the benefit period, no further deduction will be taken for that Enrolled Person until the next benefit period.

Your family maximum is also listed in the "Summary of Benefits" section. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period.

Reimbursement Levels

Your dental Plan offers different classes of covered treatment. Each class also specifies limitations and exclusions. For more information about reimbursement levels for your plan, see the “Summary of Benefits” section in the front of this benefit booklet.

Refer to the “Benefits Covered by Your Plan” section of this benefit booklet for specific Covered Dental Benefits under this Plan.

Section B – Your Benefits

Benefits Covered By Your Plan

The following are the Covered Dental Benefits under this Plan and are subject to the limitations and exclusions (refer also to “General Exclusions” section) contained in this benefit booklet. Such benefits (as defined) are available only when provided by a licensed Dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

Note: Please be sure to consult your provider before treatment begins regarding any charges that may be your responsibility.

The amounts payable by DDWA for Covered Dental Benefits are described in the “Summary of Benefits” section of this benefit booklet.

Class I Benefits

Class I Diagnostic

Covered Dental Benefits

- ◆ Comprehensive, or detailed and extensive oral evaluation.
- ◆ Diagnostic evaluation for routine or emergency purposes (dental exam).
- ◆ X-rays.

Limitations

- ◆ Comprehensive, or detailed and extensive oral evaluation is covered once in the patient’s lifetime by the same Dentist. Subsequent comprehensive or detailed and extensive oral evaluations from the same Dentist are paid as a periodic oral evaluation.
- ◆ Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited problem-focused evaluations.
- ◆ Limited problem-focused evaluations are covered twice in a benefit period.
- ◆ Bitewing x-rays are covered once in a benefit period.
- ◆ A complete series or panoramic x-ray is covered once in a five-year period from the date of service.
 - ◇ Any number or combination of x-rays, billed for the same date of service, where the combined fees are equal to or exceed the allowed fee for a complete series, will be considered a complete series for payment and benefit limitation purposes.

Exclusions

- ◆ Consultations – diagnostic services provided by a Dentist other than the requesting Dentist.
- ◆ Study models.
- ◆ Diagnostic services and x-rays related to temporomandibular joints (jaw joints) are not a Class I paid Covered Dental Benefit.

Class I Preventive

Covered Dental Benefits

- ◆ Prophylaxis (cleaning).
- ◆ Periodontal maintenance.
- ◆ Topical application of fluoride including fluoridated varnishes.

- ◆ Sealants.
- ◆ Space maintainers.
- ◆ Preventive resin restoration.

Limitations

- ◆ Any combination of prophylaxis (cleaning) and periodontal maintenance is covered twice in a benefit period.
 - ◇ Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- ◆ For any combination of adult prophylaxis (cleaning) and periodontal maintenance, third and fourth occurrences may be covered if your gums have Pocket depth readings of 5mm or greater.*
- ◆ Topical application of fluoride is limited to two covered procedures in a benefit period.
- ◆ The application of a sealant is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
 - ◇ Benefit coverage for application of sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
- ◆ Space maintainers are covered once in a patient’s lifetime through age 17 for the same quadrant.
- ◆ The application of a preventive resin restoration is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
 - ◇ Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
 - ◇ The application of a preventive resin restoration is not a Covered Dental Benefit for two years after a sealant or preventive resin restoration on the same tooth.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the “Confirmation of Treatment and Cost” section for additional information.

Exclusions

- ◆ Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits).

Class I Periodontics

Covered Dental Benefits

- ◆ Prescription-strength fluoride toothpaste.
- ◆ Prescription-strength antimicrobial rinses.

Limitations

- ◆ Prescription-strength fluoride toothpaste and antimicrobial rinse are Covered Dental Benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- ◆ Proof of a periodontal procedure must accompany the claim or the patient’s history with DDWA must show a periodontal procedure within the previous 180 days.
- ◆ Prescription-strength antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- ◆ Prescription-strength antimicrobial rinse is available during pregnancy without any periodontal procedure.

Class II Benefits

Class II Sedation

Covered Dental Benefits

- ◆ General anesthesia.
- ◆ Intravenous moderate sedation.

Limitations

- ◆ General anesthesia is a Covered Dental Benefit only in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II and III Covered Dental Benefits.*
- ◆ Intravenous moderate sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.*
- ◆ Sedation, which is either general anesthesia or intravenous moderate sedation, is a Covered Dental Benefit only once per day.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the “Confirmation of Treatment and Cost” section” for additional information.

Exclusions

- ◆ General anesthesia or intravenous moderate sedation for routine post-operative procedures is not a paid Covered Dental Benefit except as described above for children through the age of six or a physically or developmentally disabled person.

Class II Palliative Treatment

Covered Dental Benefits

- ◆ Palliative treatment for pain.

Limitations

- ◆ Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Class II Restorative

Covered Dental Benefits

- ◆ Restorations (fillings).
- ◆ Stainless steel crowns or prefabricated crowns.

Limitations

- ◆ Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- ◆ Restorations are covered for the following reasons:

- ◇ Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).
- ◇ Fracture resulting in significant loss of tooth structure (missing cusp).
- ◇ Fracture resulting in significant damage to an existing restoration.
- ◆ If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- ◆ Stainless steel crowns or prefabricated crowns are covered once in a two-year period from the date of service.

Exclusions

- ◆ Overhang removal.
- ◆ Copings.
- ◆ Re-contouring or polishing of a restoration.
- ◆ Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion.

Please also see:

- ◆ Refer to “Class III Restorative” for more information regarding coverage for crowns (other than stainless steel), inlays, veneers or onlays.

Class II Oral Surgery

Covered Dental Benefits

- ◆ Removal of teeth.
- ◆ Preparation of the mouth for insertion of dentures.
- ◆ Treatment of pathological conditions and traumatic injuries of the mouth.

Exclusions

- ◆ Bone replacement graft for ridge preservation.
- ◆ Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
- ◆ Orthognathic surgery or treatment.
- ◆ Tooth transplants.
- ◆ Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

Please also see:

- ◆ “Class II Sedation” section for additional information.

Class II Periodontics

Covered Dental Benefits

- ◆ Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.
- ◆ Periodontal scaling/root planing.
- ◆ Periodontal surgery.
- ◆ Limited adjustments to occlusion (eight teeth or fewer).
- ◆ Localized delivery of antimicrobial agents.*
- ◆ Gingivectomy.

Limitations

- ◆ Periodontal scaling/root planing is covered once per quadrant in a 36-month period from the date of service.
- ◆ Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- ◆ Periodontal surgery (per site) is covered once in a three-year period from the date of service.
 - ◇ Periodontal surgery must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- ◆ Soft tissue grafts (per site) are covered once in a three-year period from the date of service.
- ◆ Localized delivery of antimicrobial agents is a Covered Dental Benefit under certain conditions of oral health, such as periodontal Pocket depth readings of 5mm or greater.*
 - ◇ When covered, localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
 - ◇ When covered, localized delivery of antimicrobial agents must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.

*Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the “Confirmation of Treatment and Cost” section for additional information.

Please also see:

- ◆ “Class I Preventive” section for prophylaxis (cleaning) benefits.
- ◆ “Class II Sedation” section for additional information.
- ◆ “Class III Periodontics” section for complete occlusal equilibration or occlusal-guard.

Class II Endodontics

Covered Dental Benefits

- ◆ Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy, and apicoectomy.

Limitations

- ◆ Re-treatment of the same tooth is allowed only when performed by a Dentist other than the Dentist who performed the original treatment and only if the re-treatment is performed in a dental office other than the office where the original treatment was performed.
- ◆ Re-treatment of the same tooth is not a paid Covered Dental Benefit when performed by the same Dentist or in the same dental office where the original treatment was performed, within two years of the previous root canal treatment.

Exclusions

- ◆ Bleaching of teeth.

Please also see:

- ◆ “Class II Sedation” section for additional information.

Class III Benefits

Class III Periodontics

These benefits are available for patients with periodontal Pocket depth readings of 5mm or greater only, as determined by your Dentist. It is strongly recommended that prior to treatment you have your Dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

Covered Dental Benefits

- ◆ Occlusal-guard (nightguard).
- ◆ Repair and relines of occlusal-guard.
- ◆ Complete occlusal equilibration.

Limitations

- ◆ Occlusal-guard is covered once in a three-year period from the date of service.
- ◆ Repair and relines done more than six months after the date of initial placement are covered.
- ◆ Complete occlusal equilibration is covered once in a lifetime.

Class III Restorative

Covered Dental Benefits

- ◆ Crowns, veneers, and onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- ◆ Crown buildups.
- ◆ Post and core on endodontically-treated teeth.
- ◆ Implant-supported crown.

Limitations

- ◆ A crown, veneer, or onlay on the same tooth is covered once in a seven-year period from the seat date.
- ◆ An implant-supported crown on the same tooth is covered once in a seven-year period from the original seat date of a previous crown on the same tooth.
- ◆ An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the Enrolled Person, once in a two-year period from the seat date.
- ◆ Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- ◆ A crown buildup is covered for a non-endodontically treated posterior (back) tooth only when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
- ◆ A crown buildup is covered for an endodontically or a non-endodontically treated anterior (front) tooth only when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
- ◆ A crown buildup is covered once in a seven-year period on the same tooth from the date of service.
- ◆ A post and core is covered once in a seven-year period on the same tooth from the date of service.
- ◆ Crown buildups or post and cores are not a paid Covered Dental Benefit within two years of a restoration on the same tooth from the date of service.

- ◆ A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid Covered Dental Benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.

Exclusions

- ◆ Copings.
- ◆ A core buildup is not billable with placement of an onlay, 3/4 crown, or veneer.
- ◆ A crown or onlay is not a paid Covered Dental Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- ◆ A crown or onlay placed because of weakened cusps or existing large restorations.

Class III Prosthodontics

Covered Dental Benefits

- ◆ Dentures.
- ◆ Fixed partial dentures (fixed bridges).
- ◆ Inlays when used as a retainer for a fixed partial denture (fixed bridge).
- ◆ Removable partial dentures.
- ◆ Adjustment or repair of an existing prosthetic appliance.

Limitations

- ◆ Replacement of an existing fixed or removable partial denture is covered once every seven years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- ◆ Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge), and removable partial dentures shall be paid upon the seat/delivery date.
- ◆ **Temporary Denture** - DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- ◆ **Denture adjustments and relines** - Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.
- ◆ **Implants** - DDWA will allow the cost of a crown and/or appliances constructed on implants. Such allowances will be paid at the Class III payment level. Any additional cost is your responsibility. DDWA will not pay for any replacement crown and/or appliances placed within seven years from the date of placement.*

Exclusions

- ◆ Crowns in conjunction with overdentures.
- ◆ Duplicate dentures.
- ◆ Personalized dentures.
- ◆ Copings.
- ◆ Surgical placement or removal of implants or attachments to implants.
- ◆ Maintenance or cleaning of a prosthetic appliance.

*Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.

Other Benefits

Accidental Injury

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II, and Class III Covered Dental Benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused Plan Maximum. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage is available during the benefit period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

General Exclusions

This Plan does not cover every part of the dental care you may need. The benefits under this plan are subject to limitations listed above which affect the benefits you receive or how often some procedures will be covered. Additionally, there are exclusions to the type of services covered. These limitations and exclusions are detailed with the specific benefits listed above and in this General Exclusion section. These limitations and exclusions warrant careful reading.

These items are not paid Covered Dental Benefits under this Plan.

- 1) Dentistry for cosmetic reasons.
- 2) Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
- 3) Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- 4) Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
- 5) Experimental services or supplies.
 - a) This includes:
 - i) Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
 - (1) The services are in general use in the dental community in the state of Washington;
 - (2) The services are under continued scientific testing and research;
 - (3) The services show a demonstrable benefit for a particular dental condition; and
 - (4) They are proven to be safe and effective.
 - b) Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
 - c) Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such an appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.
 - d) Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review.

- 6) Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
- 7) Prescription drugs.
- 8) Laboratory tests and laboratory exams.
- 9) Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.
- 10) Charges for missed appointments.
- 11) Behavior management.
- 12) Completing claim forms.
- 13) Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), this does not include Occlusal-guard, see "Class III Periodontics" for benefit information.
- 14) Orthodontic services or supplies.
- 15) TMJ services or supplies.
- 16) This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

DDWA shall determine whether services are Covered Dental Benefits in accordance with a standard dental practice and the Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this benefit booklet and may seek judicial review of any denial of coverage of benefits.

Necessary vs. Not Covered Treatment

Your Dentist may recommend a treatment plan that includes services which may not be covered by this Plan. DDWA does not specify which treatment should be performed, only which treatment will be paid for under your Plan. While a treatment may be appropriate for managing a specific condition of oral health, it must still meet the provisions of the dental Plan in order to be a paid Covered Dental Benefit. Prior to treatment, you and your Dentist should discuss which services may not be covered as well as any fees that are your responsibility. For further information see the "Confirmation of Treatment and Cost" section.

Confirmation of Treatment and Cost

A Confirmation of Treatment and Cost, also known as a predetermination of benefits, is a request made by your Dentist to DDWA to determine your benefits for a particular service. This Confirmation of Treatment and Cost will provide you and your Dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A Confirmation of Treatment and Cost is not an authorization for services but a notification of Covered Dental Benefits available at the time the Confirmation of Treatment and Cost is made and is not a guarantee of payment (please refer to the "Initial Benefit Determination" section regarding claims requirements).

A standard Confirmation of Treatment and Cost is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete, DDWA will notify you and your Dentist in writing that additional information is required in order to process the Confirmation of Treatment and Cost. Once the additional information is available your Dentist should submit a new request for a Confirmation of Treatment and Cost to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the Confirmation of Treatment and Cost is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

Urgent Confirmation of Treatment and Cost Requests

Should a Confirmation of Treatment and Cost request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or Dentist who has knowledge of the medical condition, DDWA will review the request within 72 hours from the receipt of the request and all supporting documentation. When practical, DDWA may provide notice of the determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a Confirmation of Treatment and Cost in an emergency situation subject to the contract provisions.

Section C – Choosing a Dentist

You may select any licensed Dentist to provide services under this Plan; however, if you choose a Dentist outside of the Delta Dental PPO Network, your costs may be higher than if you were to choose a Delta Dental PPO Dentist. Dentists that do not participate in the Delta Dental PPO Network have not contracted with DDWA to charge our established PPO fees for covered services. As a result, your choice of dentists could substantially impact your out-of-pocket costs.

Once you choose a Dentist, tell them that you are covered by a DDWA dental plan and provide them the name and number of your group and your member identification number. Your group information can be found on the identification card document provided to you at enrollment, or printed from www.DeltaDentalWA.com. You may also obtain your group information and your member identification number by calling our Customer Service Department at 800-554-1907 or through our website at www.DeltaDentalWa.com.

Delta Dental of Washington uses randomly selected identification numbers or universal identifiers to ensure the privacy of your information and to help protect against identity theft.

Please note that ID cards are not required to see your Dentist, but are provided for your convenience.

Delta Dental Participating Dentists

Dentists who have agreed to provide treatment to patients covered by a DDWA plan are called 'Participating' Dentists. For your Plan, Participating Dentists may be either Delta Dental Premier Dentists or Delta Dental PPO Dentists. You can find the most current listing of Participating Dentists by going online to the Delta Dental of Washington website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

Delta Dental Premier Dentists

Premier Dentists have agreed to provide services for their filed fee under our standard agreement.

Delta Dental PPO Dentists

Our PPO Dentists have agreed to provide services at a fee lower than their original filed fee. Because of this, selecting a PPO Dentist may be a more cost effective option for you.

If you select a Delta Dental Participating Dentist they will complete and submit claim forms, and receive payment directly from DDWA on your behalf. You will not be charged more than the Participating Dentist's approved fee. You will be responsible only for stated coinsurances, deductibles, any amount over the Plan Maximum and for any elective care you choose to receive outside the Covered Dental Benefits.

Non-Participating Dentists

If you select a Dentist who is not a Delta Dental Participating Dentist, you are responsible for ensuring either you or your Dentist completes and submits a claim form. We accept any American Dental Association-approved claim form that you or your Dentist may provide. You can also download claim forms from our website at www.DeltaDentalWA.com or obtain a form by calling us at 800-554-1907.

Payment for services performed by a Non-Participating Dentist will be based on their actual charges or DDWA's maximum allowable fees for Non-Participating Dentists, whichever is less. You will be responsible for paying any balance remaining to the Dentist. Please be aware that DDWA has no control over Non-Participating Dentist's charges or billing practices.

Out-of-State Dentists

If you receive treatment from a Non-Participating Dentist outside of the state of Washington, your coinsurance amounts will be based on the coinsurance percentage established for a Delta Dental PPO Dentist. Allowable amounts paid for covered services will be based on the maximum allowable fee for a Participating Dentist in that state, or their actual fee, whichever is less.

Section D – Eligibility and Termination

Employee Eligibility and Enrollment

An Eligible Employee is an employee who meets the qualifications for eligibility established by Group.

Eligible Employees become Enrolled Employees once they have fully completed the enrollment process and DDWA has received the employer contributions for their enrollment.

New employees are eligible to enroll in this Plan on the first day of the calendar month on or after the date of hire.

You must complete the enrollment process in order to receive benefits.

Employee Termination

Eligibility and Coverage terminates at the end of the month in which you cease to be an employee, or at the end of the month for which timely payment of monthly Premiums was made by Group on your behalf to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

In the event of a suspension or termination of compensation, directly or indirectly as a result of a strike, lockout, or other labor dispute, an Enrolled Employee may continue coverage by paying the applicable Premium directly to the employer for a period not to exceed six months. Payments of premiums must be made when due, or DDWA may terminate the coverage.

The benefits under your DDWA dental Plan may be continued provided you are eligible for Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family Medical Leave Act (PFML) and you are on a leave of absence that meets the appropriate criteria. For further information, contact your employer.

Dependent Eligibility and Enrollment

Eligible Dependents are your spouse or domestic partner, and children of yours, your spouse, or your domestic partner, from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. A dependent child's spouse and/or child(ren) are not eligible for coverage under this Plan.

Non-registered domestic partnership is a relationship whereby two people:

- 1) Share the same regular and permanent residence;
- 2) Have a close personal committed relationship;
- 3) Are jointly responsible for "basic living expenses" such as food, shelter and similar expenses;
- 4) Are not married to anyone;
- 5) Are each 18 years of age or older;
- 6) Are not related by blood closer than would bar marriage in their state of residence;
- 7) Were mentally competent to consent to contract when the domestic partnership began; and
- 8) Are each other's sole domestic partner and are responsible for each other's common welfare.

Eligible Dependents may not enroll in this Plan unless the employee is an Enrolled Employee.

A new family member, with the exception of newborns, adopted and foster children, should be enrolled on the first day of the month following the date they qualify as an Eligible Dependent.

A newborn shall be covered from and after the moment of birth, and an adopted child or child placed in anticipation of adoption shall be covered from the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. A foster child is covered from the time of placement.

A child will be considered an Eligible Dependent as an adopted child if one of the following conditions are met: 1) the child has been placed with the eligible Enrolled Employee for the purpose of adoption under the laws of the state in which the employee resides; or 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption.

When additional premium is required for a newborn or adopted child or child placed in anticipation of adoption, enrollment must be received by DDWA within the timeframe listed under “Marriage, Birth and Adoption” section, which is no less than 60 days from the date of the qualifying event.

When additional premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Enrolled employees who choose not to enroll an Eligible Dependent during the initial enrollment period of the dental Plan may enroll the Eligible Dependent only during an Open Enrollment, except under special enrollment. See the “Special Enrollment” section for more information. An enrolled dependent is an Eligible Dependent that has completed the enrollment process.

Dependent Termination

Enrolled Dependent coverage terminates at the end of the month in which the enrolled employee’s coverage terminates, or when the dependent ceases to be eligible, whichever occurs first.

Unless otherwise indicated, an Enrolled Dependent shall cease to be enrolled in this Plan on the last day of the month of the Enrolled Employee’s employment, or when the person no longer meets the definition of an Eligible Dependent, or the end of the calendar month for which Group has made timely payment of the monthly Premiums on behalf of the Enrolled Employee to DDWA, or upon termination of Group’s Contract with DDWA, whichever occur first.

A Dependent may be enrolled or terminated from coverage or reinstate coverage under this Plan during Open Enrollment or during a Special Enrollment Period following a qualifying event as defined in the “Special Enrollment” section.

Other Dependent Eligibility Topics

Coverage for an Enrolled Dependent child who attains the limiting age while covered under this Plan will not be terminated if the child is and continues to be both 1) incapable of self-sustaining employment by reasons of developmental disability (attributable to intellectual disability or related conditions which include cerebral palsy, epilepsy, autism, or another neurological condition which is closely related to intellectual disability or which requires treatment similar to that required for intellectually disabled individuals) or physical disability; and 2) chiefly dependent upon the Enrolled Person for support and maintenance. Continued coverage requires that proof of incapacity and dependency be furnished to DDWA within 31 days of the dependent’s attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the Plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. If the parent is not enrolled in the Plan, the parent must enroll for coverage for both the parent and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

Special Enrollment Periods

Enrollment or termination of you or your Eligible Dependent is allowed at Open Enrollment times, and during Special Enrollment Periods, which are triggered by the following situations:

Loss of Other Coverage

If you and/or your Eligible Dependents involuntarily lose coverage or are no longer eligible under another dental plan, you may apply for coverage or make changes under this Plan if the following applies:

- ◆ You declined enrollment in this Plan.
- ◆ You lose eligibility in another health Plan or your coverage is terminated due to the following:
 - ◇ Legal separation or divorce
 - ◇ Cessation of dependent status
 - ◇ Death of Employee
 - ◇ Termination of employment or employer contributions
 - ◇ Reduction in hours
 - ◇ Loss of individual or group market coverage due to moving away from the Plan area or termination of benefit plan
 - ◇ Exhaustion of COBRA coverage
- ◆ The enrollment process must be completed within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

If these conditions are not met, you must wait until the next Open Enrollment Period, or the occurrence of another valid qualifying election event, to apply for coverage.

Marriage, Birth or Adoption

If you declined enrollment in this Plan, you may apply for coverage for yourself and your Eligible Dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support or upon placement of a child(ren) in anticipation of adoption.

- ◆ Marriage or Domestic Partner Registration – The enrollment process must be completed within 60 days from the qualifying event. If enrollment and payment are not completed within the timeframe established, any changes to enrollment can be made during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

DDWA considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefit booklet will be considered as gender neutral and applicable to individuals in domestic partnerships. DDWA and the group will follow all applicable state and federal requirements, including any applicable regulations.
- ◆ Birth – A newborn shall be covered from and after the moment of birth. The enrollment process must be completed within 90 days of the date of birth. If additional Premium for coverage is required and enrollment and payment is completed after 90 days, the enrollment becomes effective on the first day of the month in which enrollment occurs. Enrollment may be completed at any time up to the fourth birthday. Enrollment after the fourth birthday must be coincident with an Open Enrollment period or upon the occurrence of another valid qualifying election change event.
- ◆ Adoption – The enrollment process must be completed within 90 days of the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. If an additional Premium for coverage is required and enrollment and payment is not completed within the 90 days, any changes to enrollment can be made during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

Uniformed Services Employment & Re-Employment Rights Act (USERRA)

Enrolled Employees who join a branch of military service have the right to continue dental coverage as established by Group by paying the monthly Premiums, even if they are employed by groups that are too small to comply with COBRA. For further information on your rights under this act, please contact your legal counsel.

Family and Medical Leave Act (FMLA) and Paid Family Medical Leave (PFML)

The benefits for an enrolled member under this DDWA dental Plan may be continued provided the employee is eligible for the Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family Medical Leave Act (PFML) and is on a leave of absence that meets the appropriate criteria. For further information, contact your employer.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal law requires that should certain qualifying events occur which would have previously terminated coverage, coverage may continue for a period of time on a self-pay basis.

When you terminate for reasons other than gross misconduct, you may continue your dental benefits for up to 18 months by self-paying the required Premium. This option to continue dental benefits terminates if you become eligible for coverage under another group dental plan.

If a dependent no longer meets the eligibility requirements due to the death, divorce, or dissolution of domestic partnership of the employee, or does not meet the age requirement for children, coverage may continue up to three years by self-paying the required Premium. This option to continue dental benefits terminates if the dependent becomes eligible for coverage under another group dental plan.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for eligible persons.

Section E – Claim Review

Claim Forms

American Dental Association-approved claim forms may be obtained from your Dentist. You may also download claim forms from our website at www.DeltaDentalWA.com or call us at 800-554-1907 to have forms sent to you.

DDWA is not obligated to pay for treatment performed for which claim forms are submitted for payment more than six months after the date of such treatment.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to DDWA for payment modification or denial of payment. In accordance with regulatory requirements, DDWA processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, we will send you an Explanation of Benefits (EOB) that will include the following information:

- ◆ The specific reason for the denial or modification
- ◆ Reference to the specific plan provision on which the determination was based
- ◆ Your appeal rights should you wish to dispute the original determination

Appeals of Denied Claims

How to contact us

We will accept notice of an Urgent Care, Grievance, or Appeal if made by you, your covered dependent, or an authorized representative of you or your covered dependent by contacting us at the telephone number below or in writing us at the following address: Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983, or by email at memberappeals@deltadentalwa.com. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 800-554-1907.

Authorized Representative

You may authorize another person to represent you or your dependent and receive communications from DDWA regarding you or your dependent's specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed authorized representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

Informal Review

If your claim for dental benefits has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to initiate an appeal. Your first step in the appeal process is to request an informal review of the decision. Either you, or your authorized representative (see the "Authorized Representative" section), must submit your request for a review within 180 days from the date of the adverse benefit determination (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and must include the following information:

- ◆ Your name, the patient's name (if different) and ID number
- ◆ The claim number (from your Explanation of Benefits)
- ◆ The name of the Dentist

DDWA will review your request and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request a formal appeal. Your formal appeal will be reviewed by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original decision or the previous review.

Your request for a review by the Appeals Committee must be made within 90 days of the date of the letter notifying you of the informal review decision. Your request should include the information submitted with your informal review request plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim within 30 days of receiving your request. Upon completion of their review the Appeals Committee will send you written notification of their decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulations.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or an individual might be committing insurance fraud, please contact DDWA at 800-554-1907. You may also want to alert any of the appropriate law enforcement authorities including:

- ◆ The National Insurance Crime Bureau (NICB). You can reach the NICB at 800-835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- ◆ The Office of the Insurance Commissioner (OIC). You can reach the OIC at 360-725-7263 or go to www.insurance.wa.gov for more information.

Your Rights and Responsibilities

We view our benefit packages as a partnership between DDWA, our subscribers, and our Participating Dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have The Right To:

- ◆ Seek care from any licensed Dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental Participating Dentist or Non-Participating Dentist), but you can receive care from any Dentist you choose.
- ◆ Participate in decisions about your oral health care.
- ◆ Be informed about the oral health options available to you and your family.
- ◆ Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- ◆ Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care Dentist makes a specific referral for specialty care.

- ◆ Contact the DDWA Customer Service Department during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at www.DeltaDentalWA.com.
- ◆ Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage and have these issues resolved in a timely, professional and fair manner.
- ◆ Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- ◆ Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To Receive the Best Oral Health Care Possible, It Is Your Responsibility To:

- ◆ Know your benefit coverage and how it works.
- ◆ Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24-hour notice for appointment cancellations before they will waive service charges.
- ◆ Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- ◆ Give accurate and complete information about your health status and history and the health status and history of your family to all healthcare providers when necessary.
- ◆ Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- ◆ Follow instructions given by your Dentist or their staff concerning daily oral health improvement or post service care.
- ◆ Send requested documentation to DDWA to assist with the processing of claims, Confirmation of Treatment and Costs, or appeals.
- ◆ If applicable, pay the dental office any appropriate coinsurance or deductible amounts at time of visit.
- ◆ Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- ◆ Inform your Dentist and your employer promptly of any change to your, or a family member's address, telephone, or family status.

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental of Washington is committed to protecting the privacy of your dental health information in compliance with the Health Insurance Portability and Accountability Act. You can get our Notice of Privacy Practices by visiting www.DeltaDentalWA.com, or by calling DDWA at 800-554-1907.

Conversion Option

If your dental coverage stops because your employment or eligibility ends, the group policy ends, or there is an extended strike, lockout or labor dispute, you may apply directly to DDWA to convert your coverage to a Delta Dental Individual and Family plan. You must apply within 31 days of termination of your group coverage or 31 days after you receive notice of termination of coverage, whichever is later. The benefits and premium costs of a Delta Dental Individual and Family plan may be different from those available under your current plan. You may learn about our Individual and Family plans and apply for coverage online at www.DeltaDentalCoversMe.com or by calling 888-899-3734.

Extension of Benefits

In the event a person ceases to be eligible for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. An exception will be made for the completion of procedures requiring multiple visits that were started while coverage was in effect, are completed within 21 days of the termination date, and are otherwise benefits under the terms of this Plan.

Coordination of Benefits

Coordination of this Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary Plan*. The *Primary Plan* must pay benefits according to its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary Plan* is the *Secondary Plan*. The *Secondary Plan* may reduce the benefits it pays so that payments from all *Plans* do not exceed 100 percent of the total *Allowable Expense*.

Definitions: For the purpose of this section, the following definitions shall apply:

A "**Plan**" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *Plan* and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plans* or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.
- *Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state *Plan* under Medicaid; A governmental *plan*, which, by law, provides benefits that are in excess of those of any private insurance *Plan* or other nongovernmental *plan*; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plans*, unless permitted by law.

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has 2 parts and COB rules apply only to one of the 2, each of the parts is treated as a separate *Plan*.

"**This Plan**" means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other *Plans*. Any other part of the contract providing dental benefits is separate from *This Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan's* benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

“Allowable Expense” except as outlined below, means any health care expense including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering you. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary Plan would have paid if it was the primary plan. In no event will DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare’s allowable amount is the allowable expense.

An expense or a portion of an expense that is not covered by any of the *plans* is not an allowable expense. The following are examples of expenses that are not *Allowable Expenses*:

- If you are covered by 2 or more Plans that compute their benefit payments on the basis of a maximum allowable amount, relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by 2 or more *Plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of this plan’s negotiated fee is not an *Allowable Expense*.

“Closed Panel Plan” is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

“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 one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules: When you are covered by 2 or more *Plans*, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plans* state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

Each *Plan* determines its order of benefits using the first of the following rules that apply:

“Non-Dependent or Dependent” The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the 2 *Plans* is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

“Dependent Child Covered Under More Than One Plan” Unless there is a court decree stating otherwise, when a *Dependent* child is covered by more than one *Plan* the order of benefits is determined as follows:

- 1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
 - a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
 - b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
- 2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a) If a court decree states that one of the parents is responsible for the *Dependent* child’s dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
 - b) If a court decree states one parent is to assume primary financial responsibility for the *Dependent* child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
 - c) If a court decree states that both parents are responsible for the *Dependent* child’s dental expenses or dental coverage, the provisions of point 1) above (for *dependent* child(ren) whose parents are married or are living together) determine the order of benefits;
 - d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the *Dependent* child, the provisions of point 1) above (for *dependent* child(ren) whose parents are married or are living together) determine the order of benefits; or
 - e) If there is no court decree allocating responsibility for the *Dependent* child’s dental expenses or dental coverage, the order of benefits for the child is as follows:
 - I. The *Plan* covering the *Custodial Parent*, first;
 - II. The *Plan* covering the spouse of the *Custodial Parent*, second;
 - III. The *Plan* covering the *noncustodial Parent*, third; and then
 - IV. The *Plan* covering the spouse of the *noncustodial Parent*, last
- 3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of points 1) or 2) above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

“Active Employee or Retired or Laid-off Employee”: The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

“COBRA or State Continuation Coverage”: If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

“Longer or Shorter Length of Coverage”: The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expenses* must be shared equally between the *Plans* meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

Effect on the Benefits of This Plan: When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plans* during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. *Total Allowable Expense* is the *Allowable Expense* of the *Primary Plan* or the *Secondary Plan up to this plan’s allowable expense*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

How We Pay Claims When We Are Secondary: When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the *plan*.

- If there is a difference between the amounts the *plans* allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plans*.

- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plans* for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each Plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan(s)* for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

Right to Receive and Release Needed Information: Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plans*. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plans* covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

Right of Recovery: The Company has the right to recover excess payment whenever it has paid *Allowable Expenses* in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plans*.

Notice to Covered Persons If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plans* to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health *Plans* have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan's* claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

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

Subrogation

If we pay benefits under this policy, and you are paid by someone else for the same procedures we pay for, we have the right to recover what we paid from the excess received by you, after full compensation for your loss is received. Any legal fees for recovery will be pro-rated between the parties based on the percentage of the recovery received. You have to sign and deliver to us any documents relating to the recovery that we reasonably request.

Section F - Resources

Frequently Asked Questions about Your Dental Benefits

What is a Delta Dental “Participating Dentist”?

A Delta Dental Participating Dentist is a Dentist who has signed an agreement with Delta Dental stipulating that he or she will provide dental treatment to subscribers and their dependents who are covered by DDWA’s group dental care plans. Delta Dental Participating Dentists submit claims directly to DDWA for their patients.

Can I choose my own Dentist?

See the “Choosing a Dentist” section for more information.

How can I obtain a list of Delta Dental Participating Dentists?

You can obtain a current list of Delta Dental Participating Dentists by going to our website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your Dentist. You can also obtain a copy of the approved claim form from our website at www.DeltaDentalWA.com or by calling our Customer Service Number at 800-554-1907. Note: If your Dentist is a Delta Dental Participating Dentist, he or she will complete and submit claim forms for you.

What is the mailing address for DDWA claim forms?

If you see a Delta Dental Participating Dentist, the dental office will submit your claims for you. If your Dentist is not a Participating Dentist, it will be up to you to ensure that the dental office submits your claims to Delta Dental of Washington at P.O. Box 75983, Seattle, WA 98175-0983.

Who do I call if I have questions about my dental plan?

If you have questions about your dental benefits, call DDWA’s Customer Service Department at 800-554-1907. Questions can also be addressed via email at CSservice@DeltaDentalWA.com.

Does DDWA cover tooth colored fillings on my back teeth?

It is your group’s choice to cover posterior composite fillings (tooth colored fillings on your back teeth), or only allow posterior amalgam fillings (silver fillings on your back teeth). Please see the “Benefits Covered by Your Plan” section to determine which election your Group has made. You may also log on to the “MySmile® Personal Benefits Center” on our website, www.DeltaDentalWA.com, or call us at 800-554-1907 for assistance in determining whether or not your Plan covers posterior composite fillings.

Do I have to get an “estimate” before having dental treatment done?

You are not required to get an estimate before having treatment, but you may wish to do so. You may ask your Dentist to complete and submit a request for an estimate, called a Confirmation of Treatment and Cost. The estimate will provide you with estimated cost for your procedure, but is not a guarantee of payment.

Who is Delta Dental?

Delta Dental Plans Association is a national organization made up of local, nonprofit Delta Dental plans that provide dental benefits coverage. DDWA is a member of the Delta Dental Plans Association.

Glossary

Alveolar

Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam

A mostly silver filling often used to restore decayed teeth.

Apicoectomy

Surgery on the root of the tooth.

Appeal

An oral or written communication by a subscriber or their authorized representative requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage authorization, or provision of health care services or benefits.

Bitewing X-ray

An X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gum line, as well as a portion of the roots and supporting structures of these teeth.

Bridge

Also known as a fixed partial denture. See "Fixed Partial Denture".

Certificate of Coverage

The benefits booklet which describes in summary form the essential features of the contract coverage, and to or for whom the benefits hereunder are payable.

Caries

Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Complaint

An oral or written report by a subscriber or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

Comprehensive Oral Evaluation

Typically used by a general Dentist and/or specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

Contract

This agreement between DDWA and Group. The Contract constitutes the entire Contract between the parties and supersedes any prior agreement, understanding or negotiation between the parties.

Coping

A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. The purpose of a coping is to allow the removal and modification of the bridge without requiring a major remake of the bridgework, if the tooth is lost.

Covered Dental Benefits

Those dental services that are covered under this Contract, subject to the limitations set forth in "Benefits Covered by Your Plan" section.

Crown

A restoration that replaces the entire surface of the visible portion of tooth.

DDWA

Delta Dental of Washington, a nonprofit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

Delivery Date

The date a prosthetic appliance is permanently cemented into place.

Delta Dental

Delta Dental Plans Association, which is a nationwide nonprofit organization of health care service plans, which offers a range of group dental benefit plans.

Delta Dental Participating Dentist

A licensed Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written agreement between Delta Dental and such Dentist, which includes looking solely to Delta Dental for payment for covered services.

Delta Dental PPO Dentist

A Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental PPO agreement, which includes looking solely to Delta Dental for payment for covered services.

Dentist

A licensed Dentist legally authorized to practice dentistry at the time and in the place services are performed. This Plan provides for covered services only if those services are performed by or under direction of a licensed Dentist or other Licensed Professional operating within the scope of their license.

Denture

A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

Eligibility Date

The date on which an Eligible Person becomes eligible to enroll in the Plan.

Eligible Dependent

Any dependent of an Eligible Employee who meets the conditions of eligibility set forth in "Dependent Eligibility and Enrollment."

Eligible Employee

Any employee who meets the conditions of eligibility set forth in "Employee Eligibility and Enrollment."

Eligible Person

An Eligible Employee or an Eligible Dependent.

Emergency Dental Condition

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

Emergency Examination

Also known as a "limited oral evaluation – problem focused." Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

Endodontics

The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Enrolled Dependent, Enrolled Employee, Enrolled Person

Any Eligible Dependent, Eligible Employee or Eligible Person, as applicable, who has completed the enrollment process and for whom Group has submitted the monthly Premium to DDWA.

Exclusions

Those dental services that are not contract benefits set forth in your "Benefits Covered by Your Plan" section and all other services not specifically included as a Covered Dental Benefit set forth in "Benefits Covered by Your Plan" section.

Filed Fees

Approved fees that participating Delta Dental Participating Dentists have agreed to accept as the total fees for the specific services performed.

Filled Resin

Tooth colored plastic materials that contain varying amounts of special glass like particles that add strength and wear resistance.

Fixed Partial Denture

A replacement for a missing tooth or teeth. The fixed partial denture consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). They are cemented (fixed) in place and therefore are not removable.

Fluoride

A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish

A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

General Anesthesia

A drug or gas that produces unconsciousness and insensibility to pain.

Group

The employer or entity that is contracting for the dental benefits described in this benefit booklet for its employees.

Implant

A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay

A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intraoral X-rays Complete Series (including bitewings)

A series of radiographs which display the tooth and coronal portions of all the teeth in the mouth.

Intravenous (I.V.) Sedation

A form of sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

Licensed Professional

An individual legally authorized to perform services as defined in his or her license. Licensed professionals include, but are not limited to, dentist, hygienist and radiology technician. Benefits under this Contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW.

Lifetime Maximum

The maximum amount DDWA will pay in the specified covered dental benefit class for an insured individual during the time that individual is on this Plan or any other Plan offered by this Employer.

Limitations

An exception or condition of coverage for a particular Covered Dental Benefit.

Localized Delivery of Antimicrobial Agents

Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees

The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Nightguard

See "Occlusal-guard."

Non-Participating Dentist

A licensed Dentist who has not agreed to render services and receive payment in accordance with the terms and conditions of a written Member Dentist Agreement between a member of the Delta Dental Plans Association and such Dentist.

Not a paid Covered Dental Benefit

Any dental procedure that, is covered under this Plan however is not payable based on specific conditions, such as clinical criteria.

Occlusal Adjustment

Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal-Guard – (Nightguard)

A removable dental appliance – sometimes called a nightguard – that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal-guard is typically used at night.

Onlay

A restoration of the contact surface of the tooth that covers the entire surface.

Open Enrollment Period

The annual period in which subscribers can select benefits plans and add or delete Eligible Dependents.

Orthodontics

Diagnosis, prevention, and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture

A removable denture constructed over existing natural teeth or implanted studs.

Palliative Treatment

Services provided for emergency relief of dental pain.

Panoramic X-ray

An X-ray, taken from outside the mouth that shows the upper and lower teeth and the associated structures in a single picture.

Participating Plan

Delta Dental of Washington, and any other member of the Delta Dental Plans Association with which Delta Dental contracts to assist in administering the benefits described in this Benefits Booklet.

Payment Level

The applicable percentage of Maximum Allowable Fees for Covered Dental Benefits that shall be paid by DDWA as set forth in the Summary of Benefits and Reimbursement Levels sections of this Benefits Booklet.

Periodic Oral Evaluation – (Routine Examination)

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics

The diagnosis, prevention, and treatment of diseases of gums and the bone that supports teeth.

Plan

The dental benefits as provided and described in this Benefits Booklet and its accompanying Contract. Any other booklet or contract that provides dental benefits and meets the definition of a "Plan" in the "Coordination of Benefits" section of the Certificate of Coverage is a Plan for the purpose of coordination of benefits.

Pocket Depth

An internal measurement from the top of the gum tissue to its attachment on the root of a tooth.

Premium

The monthly amount payable to DDWA by Group, and/or by an Enrolled Employee to Group, as designated in the Contract.

Prophylaxis

Cleaning and polishing of teeth.

Prosthodontics

The replacement of missing teeth by artificial means such as bridges and dentures.

Pulpotomy

The removal of nerve tissue from the crown portion of a tooth.

Qualified Medical Child Support Order (QMCSO)

An order issued by a court under which a member must provide medical coverage for a dependent child. QMCSO's are often issued, for example, following a divorce or legal separation.

Resin-Based Composite

A tooth colored filling, made of a combination of materials, used to restore teeth.

Restorative

Replacing portions of lost or diseased tooth structures with a filling or crown to restore proper dental function.

Root Planing

A procedure done to smooth roughened root surfaces.

Sealants

A material applied to teeth to seal surface irregularities and prevent tooth decay.

Seat Date

The date a crown, veneer, inlay, or onlay is permanently cemented into place on the tooth.

Specialist

A licensed Dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association recognized certifying board.

Temporomandibular Joint

The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Veneer

A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention.

Nondiscrimination and Language Assistance Services

Delta Dental of Washington 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.

Delta Dental of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

We will provide free aids and services to people with disabilities to assist in communicating effectively with DDWA staff, such as:

- ◆ Qualified sign language interpreters
- ◆ Written information in other formats (large print, audio, accessible electronic formats, other formats)

We will provide free language services to assist in communicating effectively with DDWA staff for people whose primary language is not English, such as:

- ◆ Qualified interpreters
- ◆ Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: 800-554-1907. If you need translation or interpreter assistance at your dental provider's office, please contact their staff. The cost for translations and interpreter services for communication between you and your provider are not covered by DDWA.

If you believe that Delta Dental of Washington 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 our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 800-833-6384, Fx: 206 729-5512 or by email at: Compliance@DeltaDentalWA.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Compliance/Privacy Officer 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 Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- ◆ The Washington State Office of Insurance Commissioner, electronically through the Office of Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-compliant-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>.

Taglines
<p>Amharic</p> <p>እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ በራሳችሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ።</p>
<p>Arabic</p> <p>إذا كنت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907.</p>
<p>Cambodian (Mon-Khmer)</p> <p>ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាកាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែសូមទូរស័ព្ទទៅលេខ 800-554-1907។</p>
<p>Chinese</p> <p>如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。</p>
<p>Cushite (Oromo)</p> <p>Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili.</p>
<p>French</p> <p>Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907.</p>
<p>German</p> <p>Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.</p>
<p>Japanese</p> <p>ご本人様、またはお客様の身寄りの方でも Delta Dental of Washington についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907 までお電話ください。</p>
<p>Korean</p> <p>귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington 에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907 로 전화하십시오.</p>
<p>Laotian</p> <p>ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອນົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907.</p>
<p>Persian (Farsi)</p> <p>دارد، این حق را دارید که اطلاعات مورد نیازتان را به Delta Dental of Washington، یا شخصی که به وی کمک می‌کنید، سؤالی درباره‌ی تماس بگیرید. 800-554-1907 جهت صحبت با یک مترجم شفاهی، با شماره زبان خود و بدون هیچ هزینه‌ای دریافت کنید.</p>
<p>Punjabi</p> <p>ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਆਬੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।</p>

Taglines
<p>Romanian Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.</p>
<p>Russian Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.</p>
<p>Serbo-Croatian Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.</p>
<p>Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.</p>
<p>Sudan (Fulfulde) To onon, mala mo je on mballata, don mari emmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde moƴon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.</p>
<p>Tagalog Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.</p>
<p>Ukrainian Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.</p>
<p>Vietnamese Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.</p>

Your smile is part of an incredible, complex system – your body. Research shows your smile’s health influences your body’s health the same way an engine effects how a car performs. Taking care of your smile now helps prevent painful, expensive problems down the road.

Here are our top tips for a healthy smile:

- ◆ Brush for two minutes, twice a day with fluoride toothpaste
- ◆ Floss at least once a day
- ◆ Eat a well-balanced diet
- ◆ Drink fluoridated water
- ◆ Visit your Dentist at least once a year

Remember, your smile has a great service plan – your dental coverage. It makes dental visits easy and affordable.

So, why wait? Call your Dentist and schedule your next visit today. If you’re looking for a Dentist, visit www.DeltaDentalWA.com to find one near you.

Follow us online for fun, helpful tips to keep your smile healthy and get the most from your dental benefits.



Delta Dental PPOSM

Gesa Credit Union

Delta Dental of Washington

Plan Number: 09645 – Buy Up Plan

Effective Date: January 1, 2022

Welcome to your Dental Plan, administered by Delta Dental of Washington, a founding member of the nationwide Delta Dental Plans Association.

We believe everyone can enjoy good oral and overall health, with no one left behind. It drives everything we do and has been our sole focus for over 60 years.

Your plan is a resource to make it easy for you to care for your smile. This benefit booklet summarizes your coverage and describes how your benefits may be used. Understanding your benefits is the first step to getting the most from your dental plan. Review this booklet before you visit your Dentist and keep it for your reference.

You deserve a healthy smile. We're happy to help you protect it.

Questions Regarding Your Plan

If you have questions regarding your dental benefits plan, please call or email our Customer Service Department at:

800-554-1907

CService@DeltaDentalWA.com

Written inquiries may be sent to:

Delta Dental of Washington

Customer Service Department

P.O. Box 75983

Seattle, WA 98175-0983

For the most current listing of Delta Dental Participating Dentists, visit our online directory at www.DeltaDentalWA.com or call us at 800-554-1907.

Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-Blind or Speech-Disabled

Communication with Delta Dental of Washington for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with Delta Dental of Washington through specially trained communications assistants.

Dial 711 (the statewide telephone relay number) or 800-833-6384 to connect with a Washington Relay Service communications assistant. Ask them to dial Delta Dental of Washington Customer Service at 800-554-1907. They will then relay the conversation between you and our customer service representatives.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

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Section A – Summary of Benefits

Reimbursement Levels for Allowable Benefits

In-Network – Delta Dental PPO Dentists

Class I	100%
Class II	90%
Class III	60%
Orthodontic procedures	50%
Annual Deductible per Person	\$50
Annual Deductible — Family Maximum	\$150

Out-of-Network – Non-Delta Dental PPO

Class I	100%
Class II	90%
Class III	60%
Orthodontic procedures	50%
Annual Deductible per Person	\$50
Annual Deductible — Family Maximum	\$150

Plan Maximum

Annual Plan Maximum per Person	\$2,500
Lifetime Orthodontic Benefits per Person.....	\$2,500

The payment level for covered dental expenses arising as a direct result of an accidental injury is 100 percent, up to the unused Plan Maximum.

All Enrolled Employees and Enrolled Dependents are eligible for Class I, Class II, Class III Covered Dental Benefits, orthodontic benefits, and accidental injury benefits.

The annual deductible is waived for:

- ◇ Class I Covered Dental Benefits.
- ◇ Orthodontic Benefits.
- ◇ Accidental Injury Benefits.

How to use your Plan

The best way to take full advantage of your dental Plan is to know its features. You can learn them by reading this benefit booklet before you go to the Dentist. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions. If you have questions or do not understand something, please give us a call at 800-554-1907. We're more than happy to help.

Consult your provider regarding any charges that may be your responsibility before treatment begins.

Coinsurance

DDWA will pay a percentage of the cost of your treatment and you are responsible for paying the allowable balance. The part you pay is called the coinsurance. If your plan has a deductible, you are responsible for the coinsurance even after a deductible is met.

Please see your "Reimbursement Levels for Allowable Benefits" under the "Summary of Benefits" section for details on the coinsurance required by your plan.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this Plan, the benefit period is the 12-month period starting the first day of January and ending the last day of December.

Plan Maximum

The Plan Maximum is the maximum dollar amount DDWA will pay toward the cost of dental care within a specific benefit period. The maximum amount payable for Covered Dental Benefits in each benefit period is listed in the "Summary of Benefits" section in this booklet.

Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed, also known as the seat date. Amounts paid for such procedures will be applied to the Plan Maximum based on the incurred date.

Plan Deductible

Your Plan has a deductible, which can be found in the "Summary of Benefits" section. This means that from the first payment or payments DDWA makes for Covered Dental Benefits, a deduction is taken. This deduction is owed to the provider by you. Once an Enrolled Person has satisfied the deductible during the benefit period, no further deduction will be taken for that Enrolled Person until the next benefit period.

Your family maximum is also listed in the “Summary of Benefits” section. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period.

Reimbursement Levels

Your dental Plan offers different classes of covered treatment. Each class also specifies limitations and exclusions. For more information about reimbursement levels for your plan, see the “Summary of Benefits” section in the front of this benefit booklet.

Refer to the “Benefits Covered by Your Plan” section of this benefit booklet for specific Covered Dental Benefits under this Plan.

Section B – Your Benefits

Benefits Covered By Your Plan

The following are the Covered Dental Benefits under this Plan and are subject to the limitations and exclusions (refer also to “General Exclusions” section) contained in this benefit booklet. Such benefits (as defined) are available only when provided by a licensed Dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

Note: Please be sure to consult your provider before treatment begins regarding any charges that may be your responsibility.

The amounts payable by DDWA for Covered Dental Benefits are described in the “Summary of Benefits” section of this benefit booklet.

Class I Benefits

Class I Diagnostic

Covered Dental Benefits

- ◆ Comprehensive, or detailed and extensive oral evaluation.
- ◆ Diagnostic evaluation for routine or emergency purposes (dental exam).
- ◆ X-rays.

Limitations

- ◆ Comprehensive, or detailed and extensive oral evaluation is covered once in the patient’s lifetime by the same Dentist. Subsequent comprehensive or detailed and extensive oral evaluations from the same Dentist are paid as a periodic oral evaluation.
- ◆ Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited problem-focused evaluations.
- ◆ Limited problem-focused evaluations are covered twice in a benefit period.
- ◆ Bitewing x-rays are covered once in a benefit period.
- ◆ A complete series or panoramic x-ray is covered once in a five-year period from the date of service.
 - ◇ Any number or combination of x-rays, billed for the same date of service, where the combined fees are equal to or exceed the allowed fee for a complete series, will be considered a complete series for payment and benefit limitation purposes.

Exclusions

- ◆ Consultations – diagnostic services provided by a Dentist other than the requesting Dentist.
- ◆ Study models.
- ◆ Diagnostic services and x-rays related to temporomandibular joints (jaw joints) are not a Class I paid Covered Dental Benefit.

Class I Preventive

Covered Dental Benefits

- ◆ Prophylaxis (cleaning).
- ◆ Periodontal maintenance.
- ◆ Topical application of fluoride including fluoridated varnishes.

- ◆ Sealants.
- ◆ Space maintainers.
- ◆ Preventive resin restoration.

Limitations

- ◆ Any combination of prophylaxis (cleaning) and periodontal maintenance is covered twice in a benefit period.
 - ◇ Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- ◆ For any combination of adult prophylaxis (cleaning) and periodontal maintenance, third and fourth occurrences may be covered if your gums have Pocket depth readings of 5mm or greater.*
- ◆ Topical application of fluoride is limited to two covered procedures in a benefit period.
- ◆ The application of a sealant is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
 - ◇ Benefit coverage for application of sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
- ◆ Space maintainers are covered once in a patient’s lifetime through age 17 for the same quadrant.
- ◆ The application of a preventive resin restoration is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
 - ◇ Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
 - ◇ The application of a preventive resin restoration is not a Covered Dental Benefit for two years after a sealant or preventive resin restoration on the same tooth.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the “Confirmation of Treatment and Cost” section for additional information.

Exclusions

- ◆ Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits).

Class I Periodontics

Covered Dental Benefits

- ◆ Prescription-strength fluoride toothpaste.
- ◆ Prescription-strength antimicrobial rinses.

Limitations

- ◆ Prescription-strength fluoride toothpaste and antimicrobial rinse are Covered Dental Benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- ◆ Proof of a periodontal procedure must accompany the claim or the patient’s history with DDWA must show a periodontal procedure within the previous 180 days.
- ◆ Prescription-strength antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- ◆ Prescription-strength antimicrobial rinse is available during pregnancy without any periodontal procedure.

Class II Benefits

Class II Sedation

Covered Dental Benefits

- ◆ General anesthesia.
- ◆ Intravenous moderate sedation.

Limitations

- ◆ General anesthesia is a Covered Dental Benefit only in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III or Orthodontic Covered Dental Benefits.*
- ◆ Intravenous moderate sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA.*
- ◆ Sedation, which is either general anesthesia or intravenous moderate sedation, is a Covered Dental Benefit only once per day.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.

Exclusions

- ◆ General anesthesia or intravenous moderate sedation for routine post-operative procedures is not a paid Covered Dental Benefit except as described above for children through the age of six or a physically or developmentally disabled person.

Class II Palliative Treatment

Covered Dental Benefits

- ◆ Palliative treatment for pain.

Limitations

- ◆ Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Class II Restorative

Covered Dental Benefits

- ◆ Restorations (fillings).
- ◆ Stainless steel crowns or prefabricated crowns.

Limitations

- ◆ Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- ◆ Restorations are covered for the following reasons:

- ◇ Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).
- ◇ Fracture resulting in significant loss of tooth structure (missing cusp).
- ◇ Fracture resulting in significant damage to an existing restoration.
- ◆ If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspid), it will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- ◆ Stainless steel crowns or prefabricated crowns are covered once in a two-year period from the date of service.

Exclusions

- ◆ Overhang removal.
- ◆ Copings.
- ◆ Re-contouring or polishing of a restoration.
- ◆ Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion.

Please also see:

- ◆ Refer to “Class III Restorative” for more information regarding coverage for crowns (other than stainless steel), inlays, veneers or onlays.

Class II Oral Surgery

Covered Dental Benefits

- ◆ Removal of teeth.
- ◆ Preparation of the mouth for insertion of dentures.
- ◆ Treatment of pathological conditions and traumatic injuries of the mouth.

Exclusions

- ◆ Bone replacement graft for ridge preservation.
- ◆ Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
- ◆ Orthognathic surgery or treatment.
- ◆ Tooth transplants.
- ◆ Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

Please also see:

- ◆ “Class II Sedation” section for additional information.

Class II Periodontics

Covered Dental Benefits

- ◆ Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.
- ◆ Periodontal scaling/root planing.
- ◆ Periodontal surgery.
- ◆ Limited adjustments to occlusion (eight teeth or fewer).
- ◆ Localized delivery of antimicrobial agents.*
- ◆ Gingivectomy.

Limitations

- ◆ Periodontal scaling/root planing is covered once per quadrant in a 36-month period from the date of service.
- ◆ Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- ◆ Periodontal surgery (per site) is covered once in a three-year period from the date of service.
 - ◇ Periodontal surgery must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.
- ◆ Soft tissue grafts (per site) are covered once in a three-year period from the date of service.
- ◆ Localized delivery of antimicrobial agents is a Covered Dental Benefit under certain conditions of oral health, such as periodontal Pocket depth readings of 5mm or greater.*
 - ◇ When covered, localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
 - ◇ When covered, localized delivery of antimicrobial agents must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.

*Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the “Confirmation of Treatment and Cost” section for additional information.

Please also see:

- ◆ “Class I Preventive” section for prophylaxis (cleaning) benefits.
- ◆ “Class II Sedation” section for additional information.
- ◆ “Class III Periodontics” section for complete occlusal equilibration or occlusal-guard.

Class II Endodontics

Covered Dental Benefits

- ◆ Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy, and apicoectomy.

Limitations

- ◆ Re-treatment of the same tooth is allowed only when performed by a Dentist other than the Dentist who performed the original treatment and only if the re-treatment is performed in a dental office other than the office where the original treatment was performed.
- ◆ Re-treatment of the same tooth is not a paid Covered Dental Benefit when performed by the same Dentist or in the same dental office where the original treatment was performed, within two years of the previous root canal treatment.

Exclusions

- ◆ Bleaching of teeth.

Please also see:

- ◆ “Class II Sedation” section for additional information.

Class III Benefits

Class III Periodontics

These benefits are available for patients with periodontal Pocket depth readings of 5mm or greater only, as determined by your Dentist. It is strongly recommended that prior to treatment you have your Dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

Covered Dental Benefits

- ◆ Occlusal-guard (nightguard).
- ◆ Repair and relines of occlusal-guard.
- ◆ Complete occlusal equilibration.

Limitations

- ◆ Occlusal-guard is covered once in a three-year period from the date of service.
- ◆ Repair and relines done more than six months after the date of initial placement are covered.
- ◆ Complete occlusal equilibration is covered once in a lifetime.

Class III Restorative

Covered Dental Benefits

- ◆ Crowns, veneers, and onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- ◆ Crown buildups.
- ◆ Post and core on endodontically-treated teeth.
- ◆ Implant-supported crown.

Limitations

- ◆ A crown, veneer, or onlay on the same tooth is covered once in a seven-year period from the seat date.
- ◆ An implant-supported crown on the same tooth is covered once in a seven-year period from the original seat date of a previous crown on the same tooth.
- ◆ An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the Enrolled Person, once in a two-year period from the seat date.
- ◆ Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- ◆ A crown buildup is covered for a non-endodontically treated posterior (back) tooth only when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
- ◆ A crown buildup is covered for an endodontically or a non-endodontically treated anterior (front) tooth only when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
- ◆ A crown buildup is covered once in a seven-year period on the same tooth from the date of service.
- ◆ A post and core is covered once in a seven-year period on the same tooth from the date of service.
- ◆ Crown buildups or post and cores are not a paid Covered Dental Benefit within two years of a restoration on the same tooth from the date of service.

- ◆ A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid Covered Dental Benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.

Exclusions

- ◆ Copings.
- ◆ A core buildup is not billable with placement of an onlay, 3/4 crown, or veneer.
- ◆ A crown or onlay is not a paid Covered Dental Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- ◆ A crown or onlay placed because of weakened cusps or existing large restorations.

Class III Prosthodontics

Covered Dental Benefits

- ◆ Dentures.
- ◆ Fixed partial dentures (fixed bridges).
- ◆ Inlays when used as a retainer for a fixed partial denture (fixed bridge).
- ◆ Removable partial dentures.
- ◆ Adjustment or repair of an existing prosthetic appliance.
- ◆ Surgical placement or removal of implants or attachments to implants.

Limitations

- ◆ Replacement of an existing fixed or removable partial denture is covered once every seven years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- ◆ Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge), and removable partial dentures shall be paid upon the seat/delivery date.
- ◆ Implants and superstructures are covered once every seven years.
- ◆ **Temporary Denture** - DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- ◆ **Denture adjustments and relines** - Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions

- ◆ Crowns in conjunction with overdentures.
- ◆ Duplicate dentures.
- ◆ Personalized dentures.
- ◆ Copings.
- ◆ Maintenance or cleaning of a prosthetic appliance.

Other Benefits

Orthodontic Benefits for Covered Adults and Children

Orthodontic treatment is the appliance therapy necessary for the correction of teeth or jaws that are positioned improperly.

The lifetime maximum amount payable by DDWA for orthodontic benefits provided to an Enrolled Person shall be \$2,500. Not more than \$1,250 of the maximum, or one-half of DDWA's total responsibility shall be payable at the time of initial banding. Subsequent payments of DDWA's responsibility shall be made on a monthly basis throughout the length of treatment submitted, providing the employee is enrolled and the dependent is in compliance with the age limitation.

Additionally, payment for orthodontic benefits is based upon eligibility. If individuals become dis-enrolled prior to the payment of benefits, subsequent payment is not made.

Covered Dental Benefits

- ◆ Fixed or removable appliance therapy for the treatment of teeth or jaws.
- ◆ Orthodontic records: exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

- ◆ Payment is limited to:
 - ◇ Completion of the treatment plan, or any treatment that is completed while you are eligible for the Orthodontic Benefit, whichever occurs first.
 - ◇ Treatment received after coverage begins (claims must be timely submitted to DDWA). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
- ◆ Treatment that began prior to the start of coverage will be prorated. Allowable payment will be calculated based on the balance of treatment costs remaining on the date of eligibility.
- ◆ In the event of termination of the treatment plan prior to completion of the case, or termination of this plan, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

- ◆ Charges for replacement or repair of an appliance.
- ◆ Self-Administered Orthodontics.
- ◆ No benefits shall be provided for services considered inappropriate and unnecessary, as determined by DDWA.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a Confirmation of Treatment and Cost be made by, DDWA prior to commencement of treatment. A Confirmation of Treatment and Cost is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the subsequent payment of benefits, subsequent payment is not covered. If you have any questions about your Covered Dental Benefits or Plan Maximums please see the "Questions Regarding Your Plan" section on how to contact Customer Service.

Accidental Injury

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II, and Class III Covered Dental Benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused Plan Maximum. A bodily injury does not include teeth broken or damaged during the

act of chewing or biting on foreign objects. Coverage is available during the benefit period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

General Exclusions

This Plan does not cover every part of the dental care you may need. The benefits under this plan are subject to limitations listed above which affect the benefits you receive or how often some procedures will be covered. Additionally, there are exclusions to the type of services covered. These limitations and exclusions are detailed with the specific benefits listed above and in this General Exclusion section. These limitations and exclusions warrant careful reading.

These items are not paid Covered Dental Benefits under this Plan.

- 1) Dentistry for cosmetic reasons.
- 2) Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
- 3) Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- 4) Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
- 5) Experimental services or supplies.
 - a) This includes:
 - i) Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
 - (1) The services are in general use in the dental community in the state of Washington;
 - (2) The services are under continued scientific testing and research;
 - (3) The services show a demonstrable benefit for a particular dental condition; and
 - (4) They are proven to be safe and effective.
 - b) Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
 - c) Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such an appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.
 - d) Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review.
- 6) Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
- 7) Prescription drugs.
- 8) Laboratory tests and laboratory exams.
- 9) Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.

- 10) Charges for missed appointments.
- 11) Behavior management.
- 12) Completing claim forms.
- 13) Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), this does not include Occlusal-guard, see "Class III Periodontics" for benefit information.
- 14) TMJ services or supplies.
- 15) This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

DDWA shall determine whether services are Covered Dental Benefits in accordance with a standard dental practice and the Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this benefit booklet and may seek judicial review of any denial of coverage of benefits.

Necessary vs. Not Covered Treatment

Your Dentist may recommend a treatment plan that includes services which may not be covered by this Plan. DDWA does not specify which treatment should be performed, only which treatment will be paid for under your Plan. While a treatment may be appropriate for managing a specific condition of oral health, it must still meet the provisions of the dental Plan in order to be a paid Covered Dental Benefit. Prior to treatment, you and your Dentist should discuss which services may not be covered as well as any fees that are your responsibility. For further information see the "Confirmation of Treatment and Cost" section.

Confirmation of Treatment and Cost

A Confirmation of Treatment and Cost, also known as a predetermination of benefits, is a request made by your Dentist to DDWA to determine your benefits for a particular service. This Confirmation of Treatment and Cost will provide you and your Dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A Confirmation of Treatment and Cost is not an authorization for services but a notification of Covered Dental Benefits available at the time the Confirmation of Treatment and Cost is made and is not a guarantee of payment (please refer to the "Initial Benefit Determination" section regarding claims requirements).

A standard Confirmation of Treatment and Cost is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete, DDWA will notify you and your Dentist in writing that additional information is required in order to process the Confirmation of Treatment and Cost. Once the additional information is available your Dentist should submit a new request for a Confirmation of Treatment and Cost to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the Confirmation of Treatment and Cost is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

Urgent Confirmation of Treatment and Cost Requests

Should a Confirmation of Treatment and Cost request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or Dentist who has knowledge of the medical condition, DDWA will review the request within 72 hours from the receipt of the request and all supporting documentation. When practical, DDWA may provide notice of the determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a Confirmation of Treatment and Cost in an emergency situation subject to the contract provisions.

Section C – Choosing a Dentist

You may select any licensed Dentist to provide services under this Plan; however, if you choose a Dentist outside of the Delta Dental PPO Network, your costs may be higher than if you were to choose a Delta Dental PPO Dentist. Dentists that do not participate in the Delta Dental PPO Network have not contracted with DDWA to charge our established PPO fees for covered services. As a result, your choice of dentists could substantially impact your out-of-pocket costs.

Once you choose a Dentist, tell them that you are covered by a DDWA dental plan and provide them the name and number of your group and your member identification number. Your group information can be found on the identification card document provided to you at enrollment, or printed from www.DeltaDentalWA.com. You may also obtain your group information and your member identification number by calling our Customer Service Department at 800-554-1907 or through our website at www.DeltaDentalWa.com.

Delta Dental of Washington uses randomly selected identification numbers or universal identifiers to ensure the privacy of your information and to help protect against identity theft.

Please note that ID cards are not required to see your Dentist, but are provided for your convenience.

Delta Dental Participating Dentists

Dentists who have agreed to provide treatment to patients covered by a DDWA plan are called 'Participating' Dentists. For your Plan, Participating Dentists may be either Delta Dental Premier Dentists or Delta Dental PPO Dentists. You can find the most current listing of Participating Dentists by going online to the Delta Dental of Washington website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

Delta Dental Premier Dentists

Premier Dentists have agreed to provide services for their filed fee under our standard agreement.

Delta Dental PPO Dentists

Our PPO Dentists have agreed to provide services at a fee lower than their original filed fee. Because of this, selecting a PPO Dentist may be a more cost effective option for you.

If you select a Delta Dental Participating Dentist they will complete and submit claim forms, and receive payment directly from DDWA on your behalf. You will not be charged more than the Participating Dentist's approved fee. You will be responsible only for stated coinsurances, deductibles, any amount over the Plan Maximum and for any elective care you choose to receive outside the Covered Dental Benefits.

Non-Participating Dentists

If you select a Dentist who is not a Delta Dental Participating Dentist, you are responsible for ensuring either you or your Dentist completes and submits a claim form. We accept any American Dental Association-approved claim form that you or your Dentist may provide. You can also download claim forms from our website at www.DeltaDentalWA.com or obtain a form by calling us at 800-554-1907.

Payment for services performed by a Non-Participating Dentist will be based on their actual charges or DDWA's maximum allowable fees for Non-Participating Dentists, whichever is less. You will be responsible for paying any balance remaining to the Dentist. Please be aware that DDWA has no control over Non-Participating Dentist's charges or billing practices.

Out-of-State Dentists

If you receive treatment from a Non-Participating Dentist outside of the state of Washington, your coinsurance amounts will be based on the coinsurance percentage established for a Delta Dental PPO Dentist. Allowable amounts paid for covered services will be based on the maximum allowable fee for a Participating Dentist in that state, or their actual fee, whichever is less.

Section D – Eligibility and Termination

Employee Eligibility and Enrollment

An Eligible Employee is an employee who meets the qualifications for eligibility established by Group.

Eligible Employees become Enrolled Employees once they have fully completed the enrollment process and DDWA has received the employer contributions for their enrollment.

New employees are eligible to enroll in this Plan on the first day of the calendar month on or after the date of hire.

You must complete the enrollment process in order to receive benefits.

Employee Termination

Eligibility and Coverage terminates at the end of the month in which you cease to be an employee, or at the end of the month for which timely payment of monthly Premiums was made by Group on your behalf to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

In the event of a suspension or termination of compensation, directly or indirectly as a result of a strike, lockout, or other labor dispute, an Enrolled Employee may continue coverage by paying the applicable Premium directly to the employer for a period not to exceed six months. Payments of premiums must be made when due, or DDWA may terminate the coverage.

The benefits under your DDWA dental Plan may be continued provided you are eligible for Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family Medical Leave Act (PFML) and you are on a leave of absence that meets the appropriate criteria. For further information, contact your employer.

Dependent Eligibility and Enrollment

Eligible Dependents are your spouse or domestic partner, and children of yours, your spouse, or your domestic partner, from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. A dependent child's spouse and/or child(ren) are not eligible for coverage under this Plan.

Non-registered domestic partnership is a relationship whereby two people:

- 1) Share the same regular and permanent residence;
- 2) Have a close personal committed relationship;
- 3) Are jointly responsible for "basic living expenses" such as food, shelter and similar expenses;
- 4) Are not married to anyone;
- 5) Are each 18 years of age or older;
- 6) Are not related by blood closer than would bar marriage in their state of residence;
- 7) Were mentally competent to consent to contract when the domestic partnership began; and
- 8) Are each other's sole domestic partner and are responsible for each other's common welfare.

Eligible Dependents may not enroll in this Plan unless the employee is an Enrolled Employee.

A new family member, with the exception of newborns, adopted and foster children, should be enrolled on the first day of the month following the date they qualify as an Eligible Dependent.

A newborn shall be covered from and after the moment of birth, and an adopted child or child placed in anticipation of adoption shall be covered from the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. A foster child is covered from the time of placement.

A child will be considered an Eligible Dependent as an adopted child if one of the following conditions are met: 1) the child has been placed with the eligible Enrolled Employee for the purpose of adoption under the laws of the state in which the employee resides; or 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption.

When additional premium is required for a newborn or adopted child or child placed in anticipation of adoption, enrollment must be received by DDWA within the timeframe listed under “Marriage, Birth and Adoption” section, which is no less than 60 days from the date of the qualifying event.

When additional premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Enrolled employees who choose not to enroll an Eligible Dependent during the initial enrollment period of the dental Plan may enroll the Eligible Dependent only during an Open Enrollment, except under special enrollment. See the “Special Enrollment” section for more information. An enrolled dependent is an Eligible Dependent that has completed the enrollment process.

Dependent Termination

Enrolled Dependent coverage terminates at the end of the month in which the enrolled employee’s coverage terminates, or when the dependent ceases to be eligible, whichever occurs first.

Unless otherwise indicated, an Enrolled Dependent shall cease to be enrolled in this Plan on the last day of the month of the Enrolled Employee’s employment, or when the person no longer meets the definition of an Eligible Dependent, or the end of the calendar month for which Group has made timely payment of the monthly Premiums on behalf of the Enrolled Employee to DDWA, or upon termination of Group’s Contract with DDWA, whichever occur first.

A Dependent may be enrolled or terminated from coverage or reinstate coverage under this Plan during Open Enrollment or during a Special Enrollment Period following a qualifying event as defined in the “Special Enrollment” section.

Other Dependent Eligibility Topics

Coverage for an Enrolled Dependent child who attains the limiting age while covered under this Plan will not be terminated if the child is and continues to be both 1) incapable of self-sustaining employment by reasons of developmental disability (attributable to intellectual disability or related conditions which include cerebral palsy, epilepsy, autism, or another neurological condition which is closely related to intellectual disability or which requires treatment similar to that required for intellectually disabled individuals) or physical disability; and 2) chiefly dependent upon the Enrolled Person for support and maintenance. Continued coverage requires that proof of incapacity and dependency be furnished to DDWA within 31 days of the dependent’s attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the Plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. If the parent is not enrolled in the Plan, the parent must enroll for coverage for both the parent and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

Special Enrollment Periods

Enrollment or termination of you or your Eligible Dependent is allowed at Open Enrollment times, and during Special Enrollment Periods, which are triggered by the following situations:

Loss of Other Coverage

If you and/or your Eligible Dependents involuntarily lose coverage or are no longer eligible under another dental plan, you may apply for coverage or make changes under this Plan if the following applies:

- ◆ You declined enrollment in this Plan.
- ◆ You lose eligibility in another health Plan or your coverage is terminated due to the following:
 - ◇ Legal separation or divorce
 - ◇ Cessation of dependent status
 - ◇ Death of Employee
 - ◇ Termination of employment or employer contributions
 - ◇ Reduction in hours
 - ◇ Loss of individual or group market coverage due to moving away from the Plan area or termination of benefit plan
 - ◇ Exhaustion of COBRA coverage
- ◆ The enrollment process must be completed within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

If these conditions are not met, you must wait until the next Open Enrollment Period, or the occurrence of another valid qualifying election event, to apply for coverage.

Marriage, Birth or Adoption

If you declined enrollment in this Plan, you may apply for coverage for yourself and your Eligible Dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support or upon placement of a child(ren) in anticipation of adoption.

- ◆ Marriage or Domestic Partner Registration – The enrollment process must be completed within 60 days from the qualifying event. If enrollment and payment are not completed within the timeframe established, any changes to enrollment can be made during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

DDWA considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefit booklet will be considered as gender neutral and applicable to individuals in domestic partnerships. DDWA and the group will follow all applicable state and federal requirements, including any applicable regulations.
- ◆ Birth – A newborn shall be covered from and after the moment of birth. The enrollment process must be completed within 90 days of the date of birth. If additional Premium for coverage is required and enrollment and payment is completed after 90 days, the enrollment becomes effective on the first day of the month in which enrollment occurs. Enrollment may be completed at any time up to the fourth birthday. Enrollment after the fourth birthday must be coincident with an Open Enrollment period or upon the occurrence of another valid qualifying election change event.
- ◆ Adoption – The enrollment process must be completed within 90 days of the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. If an additional Premium for coverage is required and enrollment and payment is not completed within the 90 days, any changes to enrollment can be made during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

Uniformed Services Employment & Re-Employment Rights Act (USERRA)

Enrolled Employees who join a branch of military service have the right to continue dental coverage as established by Group by paying the monthly Premiums, even if they are employed by groups that are too small to comply with COBRA. For further information on your rights under this act, please contact your legal counsel.

Family and Medical Leave Act (FMLA) and Paid Family Medical Leave (PFML)

The benefits for an enrolled member under this DDWA dental Plan may be continued provided the employee is eligible for the Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family Medical Leave Act (PFML) and is on a leave of absence that meets the appropriate criteria. For further information, contact your employer.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal law requires that should certain qualifying events occur which would have previously terminated coverage, coverage may continue for a period of time on a self-pay basis.

When you terminate for reasons other than gross misconduct, you may continue your dental benefits for up to 18 months by self-paying the required Premium. This option to continue dental benefits terminates if you become eligible for coverage under another group dental plan.

If a dependent no longer meets the eligibility requirements due to the death, divorce, or dissolution of domestic partnership of the employee, or does not meet the age requirement for children, coverage may continue up to three years by self-paying the required Premium. This option to continue dental benefits terminates if the dependent becomes eligible for coverage under another group dental plan.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for eligible persons.

Section E – Claim Review

Claim Forms

American Dental Association-approved claim forms may be obtained from your Dentist. You may also download claim forms from our website at www.DeltaDentalWA.com or call us at 800-554-1907 to have forms sent to you.

DDWA is not obligated to pay for treatment performed for which claim forms are submitted for payment more than six months after the date of such treatment. For orthodontia claims, the initial banding date, which is the date the appliance is placed, is the treatment date used to start this six-month period.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to DDWA for payment modification or denial of payment. In accordance with regulatory requirements, DDWA processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, we will send you an Explanation of Benefits (EOB) that will include the following information:

- ◆ The specific reason for the denial or modification
- ◆ Reference to the specific plan provision on which the determination was based
- ◆ Your appeal rights should you wish to dispute the original determination

Appeals of Denied Claims

How to contact us

We will accept notice of an Urgent Care, Grievance, or Appeal if made by you, your covered dependent, or an authorized representative of you or your covered dependent by contacting us at the telephone number below or in writing us at the following address: Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983, or by email at memberappeals@deltadentalwa.com. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 800-554-1907.

Authorized Representative

You may authorize another person to represent you or your dependent and receive communications from DDWA regarding you or your dependent's specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed authorized representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

Informal Review

If your claim for dental benefits has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to initiate an appeal. Your first step in the appeal process is to request an informal review of the decision. Either you, or your authorized representative (see the "Authorized Representative" section), must submit your request for a review within 180 days from the date of the adverse benefit determination (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and must include the following information:

- ◆ Your name, the patient's name (if different) and ID number
- ◆ The claim number (from your Explanation of Benefits)

- ◆ The name of the Dentist

DDWA will review your request and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request a formal appeal. Your formal appeal will be reviewed by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original decision or the previous review.

Your request for a review by the Appeals Committee must be made within 90 days of the date of the letter notifying you of the informal review decision. Your request should include the information submitted with your informal review request plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim within 30 days of receiving your request. Upon completion of their review the Appeals Committee will send you written notification of their decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulations.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or an individual might be committing insurance fraud, please contact DDWA at 800-554-1907. You may also want to alert any of the appropriate law enforcement authorities including:

- ◆ The National Insurance Crime Bureau (NICB). You can reach the NICB at 800-835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- ◆ The Office of the Insurance Commissioner (OIC). You can reach the OIC at 360-725-7263 or go to www.insurance.wa.gov for more information.

Your Rights and Responsibilities

We view our benefit packages as a partnership between DDWA, our subscribers, and our Participating Dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have The Right To:

- ◆ Seek care from any licensed Dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental Participating Dentist or Non-Participating Dentist), but you can receive care from any Dentist you choose.
- ◆ Participate in decisions about your oral health care.
- ◆ Be informed about the oral health options available to you and your family.
- ◆ Request information concerning benefit coverage levels for proposed treatments prior to receiving services.

- ◆ Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care Dentist makes a specific referral for specialty care.
- ◆ Contact the DDWA Customer Service Department during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at www.DeltaDentalWA.com.
- ◆ Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage and have these issues resolved in a timely, professional and fair manner.
- ◆ Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- ◆ Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To Receive the Best Oral Health Care Possible, It Is Your Responsibility To:

- ◆ Know your benefit coverage and how it works.
- ◆ Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24-hour notice for appointment cancellations before they will waive service charges.
- ◆ Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- ◆ Give accurate and complete information about your health status and history and the health status and history of your family to all healthcare providers when necessary.
- ◆ Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- ◆ Follow instructions given by your Dentist or their staff concerning daily oral health improvement or post service care.
- ◆ Send requested documentation to DDWA to assist with the processing of claims, Confirmation of Treatment and Costs, or appeals.
- ◆ If applicable, pay the dental office any appropriate coinsurance or deductible amounts at time of visit.
- ◆ Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- ◆ Inform your Dentist and your employer promptly of any change to your, or a family member's address, telephone, or family status.

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental of Washington is committed to protecting the privacy of your dental health information in compliance with the Health Insurance Portability and Accountability Act. You can get our Notice of Privacy Practices by visiting www.DeltaDentalWA.com, or by calling DDWA at 800-554-1907.

Conversion Option

If your dental coverage stops because your employment or eligibility ends, the group policy ends, or there is an extended strike, lockout or labor dispute, you may apply directly to DDWA to convert your coverage to a Delta Dental Individual and Family plan. You must apply within 31 days of termination of your group coverage or 31 days after you receive notice of termination of coverage, whichever is later. The benefits and premium costs of a Delta Dental Individual and Family plan may be different from those available under your current plan. You may learn about our Individual and Family plans and apply for coverage online at www.DeltaDentalCoversMe.com or by calling 888-899-3734.

Extension of Benefits

In the event a person ceases to be eligible for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. An exception will be made for

the completion of procedures requiring multiple visits that were started while coverage was in effect, are completed within 21 days of the termination date, and are otherwise benefits under the terms of this Plan.

Coordination of Benefits

Coordination of this Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary Plan*. The *Primary Plan* must pay benefits according to its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary Plan* is the *Secondary Plan*. The *Secondary Plan* may reduce the benefits it pays so that payments from all *Plans* do not exceed 100 percent of the total *Allowable Expense*.

Definitions: For the purpose of this section, the following definitions shall apply:

A "***Plan***" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *Plan* and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plans* or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.
- *Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state *Plan* under Medicaid; A governmental *plan*, which, by law, provides benefits that are in excess of those of any private insurance *Plan* or other nongovernmental *plan*; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plans*, unless permitted by law.

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has 2 parts and COB rules apply only to one of the 2, each of the parts is treated as a separate *Plan*.

"***This Plan***" means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other *Plans*. Any other part of the contract providing dental benefits is separate from *This Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan's* benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

“Allowable Expense” except as outlined below, means any health care expense including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering you. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary Plan would have paid if it was the primary plan. In no event will DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare’s allowable amount is the allowable expense.

An expense or a portion of an expense that is not covered by any of the *plans* is not an allowable expense. The following are examples of expenses that are not *Allowable Expenses*:

- If you are covered by 2 or more Plans that compute their benefit payments on the basis of a maximum allowable amount, relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by 2 or more *Plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of this plan’s negotiated fee is not an *Allowable Expense*.

“Closed Panel Plan” is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

“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 one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules: When you are covered by 2 or more *Plans*, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plans* state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

Each *Plan* determines its order of benefits using the first of the following rules that apply:

“Non-Dependent or Dependent” The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the 2 *Plans* is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

“Dependent Child Covered Under More Than One Plan” Unless there is a court decree stating otherwise, when a *Dependent* child is covered by more than one *Plan* the order of benefits is determined as follows:

- 1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
 - a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
 - b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
- 2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a) If a court decree states that one of the parents is responsible for the *Dependent* child’s dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
 - b) If a court decree states one parent is to assume primary financial responsibility for the *Dependent* child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
 - c) If a court decree states that both parents are responsible for the *Dependent* child’s dental expenses or dental coverage, the provisions of point 1) above (for *dependent* child(ren) whose parents are married or are living together) determine the order of benefits;
 - d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the *Dependent* child, the provisions of point 1) above (for *dependent* child(ren) whose parents are married or are living together) determine the order of benefits; or
 - e) If there is no court decree allocating responsibility for the *Dependent* child’s dental expenses or dental coverage, the order of benefits for the child is as follows:
 - I. The *Plan* covering the *Custodial Parent*, first;
 - II. The *Plan* covering the spouse of the *Custodial Parent*, second;
 - III. The *Plan* covering the *noncustodial Parent*, third; and then
 - IV. The *Plan* covering the spouse of the *noncustodial Parent*, last
- 3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of points 1) or 2) above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

“Active Employee or Retired or Laid-off Employee”: The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

“COBRA or State Continuation Coverage”: If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

“Longer or Shorter Length of Coverage”: The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expenses* must be shared equally between the *Plans* meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

Effect on the Benefits of This Plan: When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plans* during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. *Total Allowable Expense* is the *Allowable Expense* of the *Primary Plan* or the *Secondary Plan up to this plan’s allowable expense*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

How We Pay Claims When We Are Secondary: When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the *plan*.

- If there is a difference between the amounts the *plans* allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plans*.

- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plans* for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each Plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan(s)* for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

Right to Receive and Release Needed Information: Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plans*. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plans* covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

Right of Recovery: The Company has the right to recover excess payment whenever it has paid *Allowable Expenses* in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plans*.

Notice to Covered Persons If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plans* to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health *Plans* have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan's* claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

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

Subrogation

If we pay benefits under this policy, and you are paid by someone else for the same procedures we pay for, we have the right to recover what we paid from the excess received by you, after full compensation for your loss is received. Any legal fees for recovery will be pro-rated between the parties based on the percentage of the recovery received. You have to sign and deliver to us any documents relating to the recovery that we reasonably request.

Section F - Resources

Frequently Asked Questions about Your Dental Benefits

What is a Delta Dental “Participating Dentist”?

A Delta Dental Participating Dentist is a Dentist who has signed an agreement with Delta Dental stipulating that he or she will provide dental treatment to subscribers and their dependents who are covered by DDWA’s group dental care plans. Delta Dental Participating Dentists submit claims directly to DDWA for their patients.

Can I choose my own Dentist?

See the “Choosing a Dentist” section for more information.

How can I obtain a list of Delta Dental Participating Dentists?

You can obtain a current list of Delta Dental Participating Dentists by going to our website at www.DeltaDentalWA.com. You may also call us at 800-554-1907.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your Dentist. You can also obtain a copy of the approved claim form from our website at www.DeltaDentalWA.com or by calling our Customer Service Number at 800-554-1907. Note: If your Dentist is a Delta Dental Participating Dentist, he or she will complete and submit claim forms for you.

What is the mailing address for DDWA claim forms?

If you see a Delta Dental Participating Dentist, the dental office will submit your claims for you. If your Dentist is not a Participating Dentist, it will be up to you to ensure that the dental office submits your claims to Delta Dental of Washington at P.O. Box 75983, Seattle, WA 98175-0983.

Who do I call if I have questions about my dental plan?

If you have questions about your dental benefits, call DDWA’s Customer Service Department at 800-554-1907. Questions can also be addressed via email at CSservice@DeltaDentalWA.com.

Does DDWA cover tooth colored fillings on my back teeth?

It is your group’s choice to cover posterior composite fillings (tooth colored fillings on your back teeth), or only allow posterior amalgam fillings (silver fillings on your back teeth). Please see the “Benefits Covered by Your Plan” section to determine which election your Group has made. You may also log on to the “MySmile® Personal Benefits Center” on our website, www.DeltaDentalWA.com, or call us at 800-554-1907 for assistance in determining whether or not your Plan covers posterior composite fillings.

Do I have to get an “estimate” before having dental treatment done?

You are not required to get an estimate before having treatment, but you may wish to do so. You may ask your Dentist to complete and submit a request for an estimate, called a Confirmation of Treatment and Cost. The estimate will provide you with estimated cost for your procedure, but is not a guarantee of payment.

Who is Delta Dental?

Delta Dental Plans Association is a national organization made up of local, nonprofit Delta Dental plans that provide dental benefits coverage. DDWA is a member of the Delta Dental Plans Association.

Glossary

Alveolar

Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam

A mostly silver filling often used to restore decayed teeth.

Apicoectomy

Surgery on the root of the tooth.

Appeal

An oral or written communication by a subscriber or their authorized representative requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage authorization, or provision of health care services or benefits.

Bitewing X-ray

An X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gum line, as well as a portion of the roots and supporting structures of these teeth.

Bridge

Also known as a fixed partial denture. See "Fixed Partial Denture".

Certificate of Coverage

The benefits booklet which describes in summary form the essential features of the contract coverage, and to or for whom the benefits hereunder are payable.

Caries

Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Complaint

An oral or written report by a subscriber or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

Comprehensive Oral Evaluation

Typically used by a general Dentist and/or specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

Contract

This agreement between DDWA and Group. The Contract constitutes the entire Contract between the parties and supersedes any prior agreement, understanding or negotiation between the parties.

Coping

A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. The purpose of a coping is to allow the removal and modification of the bridge without requiring a major remake of the bridgework, if the tooth is lost.

Covered Dental Benefits

Those dental services that are covered under this Contract, subject to the limitations set forth in "Benefits Covered by Your Plan" section.

Crown

A restoration that replaces the entire surface of the visible portion of tooth.

DDWA

Delta Dental of Washington, a nonprofit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

Delivery Date

The date a prosthetic appliance is permanently cemented into place.

Delta Dental

Delta Dental Plans Association, which is a nationwide nonprofit organization of health care service plans, which offers a range of group dental benefit plans.

Delta Dental Participating Dentist

A licensed Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written agreement between Delta Dental and such Dentist, which includes looking solely to Delta Dental for payment for covered services.

Delta Dental PPO Dentist

A Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental PPO agreement, which includes looking solely to Delta Dental for payment for covered services.

Dentist

A licensed Dentist legally authorized to practice dentistry at the time and in the place services are performed. This Plan provides for covered services only if those services are performed by or under direction of a licensed Dentist or other Licensed Professional operating within the scope of their license.

Denture

A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

Eligibility Date

The date on which an Eligible Person becomes eligible to enroll in the Plan.

Eligible Dependent

Any dependent of an Eligible Employee who meets the conditions of eligibility set forth in "Dependent Eligibility and Enrollment."

Eligible Employee

Any employee who meets the conditions of eligibility set forth in "Employee Eligibility and Enrollment."

Eligible Person

An Eligible Employee or an Eligible Dependent.

Emergency Dental Condition

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

Emergency Examination

Also known as a "limited oral evaluation – problem focused." Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

Endodontics

The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Enrolled Dependent, Enrolled Employee, Enrolled Person

Any Eligible Dependent, Eligible Employee or Eligible Person, as applicable, who has completed the enrollment process and for whom Group has submitted the monthly Premium to DDWA.

Exclusions

Those dental services that are not contract benefits set forth in your "Benefits Covered by Your Plan" section and all other services not specifically included as a Covered Dental Benefit set forth in "Benefits Covered by Your Plan" section.

Filed Fees

Approved fees that participating Delta Dental Participating Dentists have agreed to accept as the total fees for the specific services performed.

Filled Resin

Tooth colored plastic materials that contain varying amounts of special glass like particles that add strength and wear resistance.

Fixed Partial Denture

A replacement for a missing tooth or teeth. The fixed partial denture consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). They are cemented (fixed) in place and therefore are not removable.

Fluoride

A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish

A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

General Anesthesia

A drug or gas that produces unconsciousness and insensibility to pain.

Group

The employer or entity that is contracting for the dental benefits described in this benefit booklet for its employees.

Implant

A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay

A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intraoral X-rays Complete Series (including bitewings)

A series of radiographs which display the tooth and coronal portions of all the teeth in the mouth.

Intravenous (I.V.) Sedation

A form of sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

Licensed Professional

An individual legally authorized to perform services as defined in his or her license. Licensed professionals include, but are not limited to, dentist, hygienist and radiology technician. Benefits under this Contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW.

Lifetime Maximum

The maximum amount DDWA will pay in the specified covered dental benefit class for an insured individual during the time that individual is on this Plan or any other Plan offered by this Employer.

Limitations

An exception or condition of coverage for a particular Covered Dental Benefit.

Localized Delivery of Antimicrobial Agents

Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees

The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Nightguard

See "Occlusal-guard."

Non-Participating Dentist

A licensed Dentist who has not agreed to render services and receive payment in accordance with the terms and conditions of a written Member Dentist Agreement between a member of the Delta Dental Plans Association and such Dentist.

Not a paid Covered Dental Benefit

Any dental procedure that, is covered under this Plan however is not payable based on specific conditions, such as clinical criteria.

Occlusal Adjustment

Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal-Guard – (Nightguard)

A removable dental appliance – sometimes called a nightguard – that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal-guard is typically used at night.

Onlay

A restoration of the contact surface of the tooth that covers the entire surface.

Open Enrollment Period

The annual period in which subscribers can select benefits plans and add or delete Eligible Dependents.

Orthodontics

Diagnosis, prevention, and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture

A removable denture constructed over existing natural teeth or implanted studs.

Palliative Treatment

Services provided for emergency relief of dental pain.

Panoramic X-ray

An X-ray, taken from outside the mouth that shows the upper and lower teeth and the associated structures in a single picture.

Participating Plan

Delta Dental of Washington, and any other member of the Delta Dental Plans Association with which Delta Dental contracts to assist in administering the benefits described in this Benefits Booklet.

Payment Level

The applicable percentage of Maximum Allowable Fees for Covered Dental Benefits that shall be paid by DDWA as set forth in the Summary of Benefits and Reimbursement Levels sections of this Benefits Booklet.

Periodic Oral Evaluation – (Routine Examination)

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics

The diagnosis, prevention, and treatment of diseases of gums and the bone that supports teeth.

Plan

The dental benefits as provided and described in this Benefits Booklet and its accompanying Contract. Any other booklet or contract that provides dental benefits and meets the definition of a "Plan" in the "Coordination of Benefits" section of the Certificate of Coverage is a Plan for the purpose of coordination of benefits.

Pocket Depth

An internal measurement from the top of the gum tissue to its attachment on the root of a tooth.

Premium

The monthly amount payable to DDWA by Group, and/or by an Enrolled Employee to Group, as designated in the Contract.

Prophylaxis

Cleaning and polishing of teeth.

Prosthodontics

The replacement of missing teeth by artificial means such as bridges and dentures.

Pulpotomy

The removal of nerve tissue from the crown portion of a tooth.

Qualified Medical Child Support Order (QMCSO)

An order issued by a court under which a member must provide medical coverage for a dependent child. QMCSO's are often issued, for example, following a divorce or legal separation.

Resin-Based Composite

A tooth colored filling, made of a combination of materials, used to restore teeth.

Restorative

Replacing portions of lost or diseased tooth structures with a filling or crown to restore proper dental function.

Root Planing

A procedure done to smooth roughened root surfaces.

Sealants

A material applied to teeth to seal surface irregularities and prevent tooth decay.

Seat Date

The date a crown, veneer, inlay, or onlay is permanently cemented into place on the tooth.

Specialist

A licensed Dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association recognized certifying board.

Temporomandibular Joint

The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Veneer

A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention.

Nondiscrimination and Language Assistance Services

Delta Dental of Washington 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.

Delta Dental of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

We will provide free aids and services to people with disabilities to assist in communicating effectively with DDWA staff, such as:

- ◆ Qualified sign language interpreters
- ◆ Written information in other formats (large print, audio, accessible electronic formats, other formats)

We will provide free language services to assist in communicating effectively with DDWA staff for people whose primary language is not English, such as:

- ◆ Qualified interpreters
- ◆ Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: 800-554-1907. If you need translation or interpreter assistance at your dental provider's office, please contact their staff. The cost for translations and interpreter services for communication between you and your provider are not covered by DDWA.

If you believe that Delta Dental of Washington 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 our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 800-833-6384, Fx: 206 729-5512 or by email at: Compliance@DeltaDentalWA.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Compliance/Privacy Officer 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 Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- ◆ The Washington State Office of Insurance Commissioner, electronically through the Office of Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-compliant-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>.

Taglines
<p>Amharic</p> <p>እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ በራሳችሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ።</p>
<p>Arabic</p> <p>إذا كانت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907.</p>
<p>Cambodian (Mon-Khmer)</p> <p>ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាកាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែសូមទូរស័ព្ទទៅលេខ 800-554-1907។</p>
<p>Chinese</p> <p>如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。</p>
<p>Cushite (Oromo)</p> <p>Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili.</p>
<p>French</p> <p>Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907.</p>
<p>German</p> <p>Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.</p>
<p>Japanese</p> <p>ご本人様、またはお客様の身寄りの方でも Delta Dental of Washington についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907 までお電話ください。</p>
<p>Korean</p> <p>귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington 에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907 로 전화하십시오.</p>
<p>Laotian</p> <p>ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອນົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907.</p>
<p>Persian (Farsi)</p> <p>دارد، این حق را دارید که اطلاعات مورد نیازتان را به Delta Dental of Washington، یا شخصی که به وی کمک می کنید، سؤالی درباره‌ی تماس بگیرید. 800-554-1907 جهت صحبت با یک مترجم شفاهی، با شماره زبان خود و بدون هیچ هزینه‌ای دریافت کنید.</p>
<p>Punjabi</p> <p>ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਆਬੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।</p>

Taglines
<p>Romanian Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.</p>
<p>Russian Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.</p>
<p>Serbo-Croatian Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.</p>
<p>Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.</p>
<p>Sudan (Fulfulde) To onon, mala mo je on mballata, don mari emmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde modon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.</p>
<p>Tagalog Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.</p>
<p>Ukrainian Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.</p>
<p>Vietnamese Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.</p>

Your smile is part of an incredible, complex system – your body. Research shows your smile’s health influences your body’s health the same way an engine effects how a car performs. Taking care of your smile now helps prevent painful, expensive problems down the road.

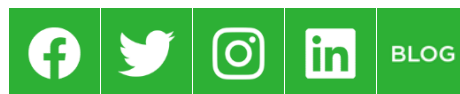
Here are our top tips for a healthy smile:

- ◆ Brush for two minutes, twice a day with fluoride toothpaste
- ◆ Floss at least once a day
- ◆ Eat a well-balanced diet
- ◆ Drink fluoridated water
- ◆ Visit your Dentist at least once a year

Remember, your smile has a great service plan – your dental coverage. It makes dental visits easy and affordable.

So, why wait? Call your Dentist and schedule your next visit today. If you’re looking for a Dentist, visit www.DeltaDentalWA.com to find one near you.

Follow us online for fun, helpful tips to keep your smile healthy and get the most from your dental benefits.



Summary of Benefits

Gesa Credit Union

All Eligible Employees

Basic Term Life, Basic Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Optional Accidental Death & Dismemberment, Short Term Disability and Long Term Disability

Issued by The Prudential Insurance Company of America

Basic Term Life

- 100% Employer Paid
- Basic Term Life: You are automatically enrolled for 2.0 times your covered annual earnings to \$500,000. **Please refer to your plan certificate(s) to review the required minimum and maximum coverage amounts allowed.**
 - If you are terminally ill, you can get a partial payment of your group life insurance benefit. You can use this payment as you see fit. The payment to your beneficiary will be reduced by the amount you receive with the Accelerated Benefit Option.* Refer to the plan booklet for details.
 - Payment of premium can be waived if you are totally disabled for 6 months, you are less than 60 years old when the disability begins, and you continue to be totally disabled. This waiver terminates at your normal retirement age under the Social Security Act. This provision may vary by state. Refer to the plan booklet for details.
 - Coverage will be reduced as you age - by 35% at age 75 and 50% at age 80.
 - Coverage will end on your termination of employment or as specified in the plan booklet. You may convert your insurance to an individual life insurance policy issued by the Prudential Insurance Company of America.

Basic Accidental Death & Dismemberment

- 100% Employer Paid
- Basic AD&D pays you and your beneficiary a benefit for the loss of life or other injuries resulting from a covered accident -- 100% for loss of life and a lesser percentage for other injuries. Injuries covered may include loss of sight or speech, paralysis, and dismemberment of hands or feet. Basic AD&D benefits are paid regardless of other coverages you may have.
 - Basic AD&D: You are automatically enrolled for an amount equal to your Basic Term Life coverage amount.

Optional Term Life

- 100% Employee Paid
- Purchase coverage in increments of \$5,000 up to a maximum of \$500,000, not to exceed 5.0 times your covered annual earnings. **Please refer to your plan certificate(s) to review the required minimum and maximum coverage amounts allowed.**
 - If enrolling when first eligible within the specified period of your date of hire, you can elect up to the guaranteed issue amount of \$250,000, without providing proof of good health to Prudential.
 - If you have been previously denied coverage in the past, proof of good health satisfactory to Prudential is required for all coverage amounts.
 - All other elections or enrolling after the enrollment period will require proof of good health satisfactory to Prudential for all coverage amounts.
 - If terminally ill, you can get a partial payment of your group term life insurance benefit. You can use this payment as you see fit. In the event of your death, your beneficiary will receive a benefit payout which has been reduced by the amount you receive.
 - Payment of premium can be waived if you are totally disabled for 6 months, you are less than 60 years old when the disability begins, and you continue to be totally disabled. This waiver terminates at your normal retirement age under the Social Security Act. This provision may vary by state. Refer to the plan booklet for details.
 - Coverage will be reduced as you age - by 35% at age 75 and 50% at age 80.
 - Upon termination of employment, you (if eligible to port) may choose to continue a coverage amount equal to or lower than your current benefit amount. Coverage amounts will be subject to maximum of five times your annual earnings or \$1 million, whichever is less.

Spouse - Dependent Term Life

- 100% Employee Paid
- Purchase coverage for your spouse in increments of \$5,000 up to a maximum of \$250,000. **Please note:** The Dependent Term Life Insurance coverage amount on your spouse may not exceed 50% of your Optional Term Life coverage amount.
 - If enrolling your spouse when first eligible, you can elect up to the guaranteed issue amount of \$20,000, on your spouse without providing proof of good health to Prudential.
 - All other elections or enrolling after the enrollment period will require proof of good health satisfactory to Prudential for all coverage amounts.
 - If your spouse has been previously denied coverage in the past, proof of good health satisfactory to Prudential is required for all coverage amounts.
 - Coverage will be reduced as you age - by 35% at age 75 and 50% at age 80.
 - Upon termination of employment, your spouse (if eligible to port) may choose to continue a coverage amount equal to or lower than your current benefit amount. Coverage amounts for you and your spouse will be subject to a maximum of five times your annual earnings or \$1 million, whichever is less.
-

Child - Dependent Term Life

- 100% Employee Paid
- Purchase coverage for \$10,000. **Please note:** The Optional Dependent Term Life Insurance coverage amount on your children may not exceed 50% of your Optional Term Life coverage amount. There are no health requirements for this coverage.
 - Coverage begins from live birth, and continues to age 26.
 - Upon termination of employment, you (if eligible to port) may choose to continue a dependent child coverage amount equal to or lower than your current benefit amount.
-

Employee - Optional Accidental Death & Dismemberment

- 100% Employee Paid
- Purchase an Optional AD&D Insurance coverage amount equal to your Optional Term Life Insurance coverage amount.
 - Coverage will be reduced as you age - by 35% at age 75 and 50% at age 80.
-

Spouse - Optional Accidental Death & Dismemberment

- 100% Employee Paid
- Purchase an Optional AD&D Insurance coverage amount for your spouse equal to your spouse's Dependent Term Life Insurance coverage amount.
 - Coverage will be reduced as you age - by 35% at age 75 and 50% at age 80.
-

Child - Optional Accidental Death & Dismemberment

- 100% Employee Paid
- Purchase an Optional AD&D Insurance coverage amount for your child(ren) equal to your child(ren)'s Dependent Term Life Insurance coverage amount.
 - Coverage begins from live birth and continues to age 26.
-

Short Term Disability

- 100% Employer Paid
- Your weekly Short Term Disability benefit will be 60% of your weekly pre-disability earnings, up to a maximum of \$2,769, less deductible sources of income. The minimum weekly benefit is \$15.
 - Deductible sources of income may include benefits from statutory plans, unemployment income and salary continuation.
 - If you meet the definition of disability, your benefits will begin on the 15th day following a non-occupational injury or the 15th day following a non-occupational sickness. The benefit duration is 11 weeks. You are considered disabled when, because of injury or sickness, you are under the regular care of the doctor, are unable to perform the material and substantial duties of your regular occupation and your disability results in a loss of weekly income of at least 20%.
 - You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.

Long Term Disability

- 100% Employer Paid
- Your monthly Long Term Disability benefit will be 60% of your monthly pre-disability earnings, up to the maximum of \$15,000, less deductible sources of income. The minimum monthly benefit is \$100.
 - Deductible sources of income may include benefits from statutory plans, Social Security to you and your dependents, workers' compensation, unemployment income and other income.
 - If you meet the definition of disability, your benefits will begin 90 days following an accidental injury or sickness. The benefit duration is up to your normal retirement age under the Social Security Act. However, if you become disabled at or after age 65 benefits are payable according to an age-based schedule. Refer to the Booklet-Certificate for details.
 - You are considered disabled when, because of injury or sickness, you are under the regular care of a doctor, you are unable to perform the material and substantial duties of your regular occupation and your disability results in a loss of income of at least 20%. After receiving benefits for 60 months, you are considered disabled when, due to the same sickness or injury, you are unable to perform the material and substantial duties of any gainful occupation for which you are reasonably fitted by education, training or experience, and disability results in a loss of income of a specified percentage determined by your plan.
 - Disabilities due to mental illness are limited to 24 months of benefits during your lifetime. Examples of mental illness include schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, substance related disorders (including drug and alcohol abuse), and/or adjustment disorders. Disabilities due to mental illness have a combined limited pay period during your lifetime.
 - LTD benefits will not be paid for a disability that begins during the first 12 months of coverage and due to a pre-existing condition. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, diagnostic measures, prescribed drugs or medicines, or for which you followed treatment recommendations during the 3 months prior to your effective date of coverage.
 - During the first 12 months of part-time work while disabled, you can receive full benefits as long as your combined income and disability benefits do not exceed your monthly pre-disability earnings.
 - If you die while collecting disability benefits, a lump sum payment may be paid to your eligible survivors.
 - You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.

Benefits, exclusions and provisions may vary by state. Refer to the plan booklet for details.

For your coverage to become effective, you must be actively at work on the effective date of the plan. If you apply for an amount that requires satisfactory evidence of insurability to The Prudential Insurance Company of America, you must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

*Accelerated Death Benefit option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered "terminally ill" or "chronically ill." You may wish to seek professional tax advice before exercising this option.

This coverage is not health insurance coverage (often referred to as “Major Medical Coverage”).

This type of plan is NOT considered “minimum essential coverage” under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

IMPORTANT NOTICE - THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

North Carolina residents: THIS IS NOT A MEDICARE SUPPLEMENT PLAN. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

Group Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ 07102. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply. Contract Series: 83500

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Rate Sheet

Gesa Credit Union

All Eligible Employees

Issued by The Prudential Insurance Company of America

Effective: 1/1/2020

Employee - Optional Term Life Monthly Cost per Coverage Amount

Coverage is available in increments of \$5,000 to a maximum of \$500,000, not to exceed 5.0 times your covered annual earnings. Refer to the Optional Term Life section for evidence of insurability details. Initial rates based on age as of effective date of your coverage. Rates will change based on the following age schedule.

Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	\$110,000	\$120,000	\$130,000
< 25	\$0.43	\$0.86	\$1.29	\$1.72	\$2.15	\$2.58	\$3.01	\$3.44	\$3.87	\$4.30	\$4.73	\$5.16	\$5.59
25-29	\$0.51	\$1.02	\$1.53	\$2.04	\$2.55	\$3.06	\$3.57	\$4.08	\$4.59	\$5.10	\$5.61	\$6.12	\$6.63
30-34	\$0.68	\$1.36	\$2.04	\$2.72	\$3.40	\$4.08	\$4.76	\$5.44	\$6.12	\$6.80	\$7.48	\$8.16	\$8.84
35-39	\$0.77	\$1.54	\$2.31	\$3.08	\$3.85	\$4.62	\$5.39	\$6.16	\$6.93	\$7.70	\$8.47	\$9.24	\$10.01
40-44	\$0.86	\$1.72	\$2.58	\$3.44	\$4.30	\$5.16	\$6.02	\$6.88	\$7.74	\$8.60	\$9.46	\$10.32	\$11.18
45-49	\$1.29	\$2.58	\$3.87	\$5.16	\$6.45	\$7.74	\$9.03	\$10.32	\$11.61	\$12.90	\$14.19	\$15.48	\$16.77
50-54	\$1.88	\$3.76	\$5.64	\$7.52	\$9.40	\$11.28	\$13.16	\$15.04	\$16.92	\$18.80	\$20.68	\$22.56	\$24.44
55-59	\$3.59	\$7.18	\$10.77	\$14.36	\$17.95	\$21.54	\$25.13	\$28.72	\$32.31	\$35.90	\$39.49	\$43.08	\$46.67
60-64	\$5.47	\$10.94	\$16.41	\$21.88	\$27.35	\$32.82	\$38.29	\$43.76	\$49.23	\$54.70	\$60.17	\$65.64	\$71.11
65-69	\$10.60	\$21.20	\$31.80	\$42.40	\$53.00	\$63.60	\$74.20	\$84.80	\$95.40	\$106.00	\$116.60	\$127.20	\$137.80
70+	\$17.70	\$35.40	\$53.10	\$70.80	\$88.50	\$106.20	\$123.90	\$141.60	\$159.30	\$177.00	\$194.70	\$212.40	\$230.10

Age	\$140,000	\$150,000	\$160,000	\$170,000	\$180,000	\$190,000	\$200,000	\$210,000	\$220,000	\$230,000	\$240,000	\$250,000	\$260,000
< 25	\$6.02	\$6.45	\$6.88	\$7.31	\$7.74	\$8.17	\$8.60	\$9.03	\$9.46	\$9.89	\$10.32	\$10.75	\$11.18
25-29	\$7.14	\$7.65	\$8.16	\$8.67	\$9.18	\$9.69	\$10.20	\$10.71	\$11.22	\$11.73	\$12.24	\$12.75	\$13.26
30-34	\$9.52	\$10.20	\$10.88	\$11.56	\$12.24	\$12.92	\$13.60	\$14.28	\$14.96	\$15.64	\$16.32	\$17.00	\$17.68
35-39	\$10.78	\$11.55	\$12.32	\$13.09	\$13.86	\$14.63	\$15.40	\$16.17	\$16.94	\$17.71	\$18.48	\$19.25	\$20.02
40-44	\$12.04	\$12.90	\$13.76	\$14.62	\$15.48	\$16.34	\$17.20	\$18.06	\$18.92	\$19.78	\$20.64	\$21.50	\$22.36
45-49	\$18.06	\$19.35	\$20.64	\$21.93	\$23.22	\$24.51	\$25.80	\$27.09	\$28.38	\$29.67	\$30.96	\$32.25	\$33.54
50-54	\$26.32	\$28.20	\$30.08	\$31.96	\$33.84	\$35.72	\$37.60	\$39.48	\$41.36	\$43.24	\$45.12	\$47.00	\$48.88
55-59	\$50.26	\$53.85	\$57.44	\$61.03	\$64.62	\$68.21	\$71.80	\$75.39	\$78.98	\$82.57	\$86.16	\$89.75	\$93.34
60-64	\$76.58	\$82.05	\$87.52	\$92.99	\$98.46	\$103.93	\$109.40	\$114.87	\$120.34	\$125.81	\$131.28	\$136.75	\$142.22
65-69	\$148.40	\$159.00	\$169.60	\$180.20	\$190.80	\$201.40	\$212.00	\$222.60	\$233.20	\$243.80	\$254.40	\$265.00	\$275.60
70+	\$247.80	\$265.50	\$283.20	\$300.90	\$318.60	\$336.30	\$354.00	\$371.70	\$389.40	\$407.10	\$424.80	\$442.50	\$460.20

Employee - Optional Term Life Monthly Cost per Coverage Amount

Coverage is available in increments of \$5,000 to a maximum of \$500,000, not to exceed 5.0 times your covered annual earnings. Refer to the Optional Term Life section for evidence of insurability details. Initial rates based on age as of effective date of your coverage. Rates will change based on the following age schedule.

	\$270,000	\$280,000	\$290,000	\$300,000	\$310,000	\$320,000	\$330,000	\$340,000	\$350,000	\$360,000	\$370,000	\$380,000
Age												
< 25	\$11.61	\$12.04	\$12.47	\$12.90	\$13.33	\$13.76	\$14.19	\$14.62	\$15.05	\$15.48	\$15.91	\$16.34
25-29	\$13.77	\$14.28	\$14.79	\$15.30	\$15.81	\$16.32	\$16.83	\$17.34	\$17.85	\$18.36	\$18.87	\$19.38
30-34	\$18.36	\$19.04	\$19.72	\$20.40	\$21.08	\$21.76	\$22.44	\$23.12	\$23.80	\$24.48	\$25.16	\$25.84
35-39	\$20.79	\$21.56	\$22.33	\$23.10	\$23.87	\$24.64	\$25.41	\$26.18	\$26.95	\$27.72	\$28.49	\$29.26
40-44	\$23.22	\$24.08	\$24.94	\$25.80	\$26.66	\$27.52	\$28.38	\$29.24	\$30.10	\$30.96	\$31.82	\$32.68
45-49	\$34.83	\$36.12	\$37.41	\$38.70	\$39.99	\$41.28	\$42.57	\$43.86	\$45.15	\$46.44	\$47.73	\$49.02
50-54	\$50.76	\$52.64	\$54.52	\$56.40	\$58.28	\$60.16	\$62.04	\$63.92	\$65.80	\$67.68	\$69.56	\$71.44
55-59	\$96.93	\$100.52	\$104.11	\$107.70	\$111.29	\$114.88	\$118.47	\$122.06	\$125.65	\$129.24	\$132.83	\$136.42
60-64	\$147.69	\$153.16	\$158.63	\$164.10	\$169.57	\$175.04	\$180.51	\$185.98	\$191.45	\$196.92	\$202.39	\$207.86
65-69	\$286.20	\$296.80	\$307.40	\$318.00	\$328.60	\$339.20	\$349.80	\$360.40	\$371.00	\$381.60	\$392.20	\$402.80
70+	\$477.90	\$495.60	\$513.30	\$531.00	\$548.70	\$566.40	\$584.10	\$601.80	\$619.50	\$637.20	\$654.90	\$672.60

	\$390,000	\$400,000	\$410,000	\$420,000	\$430,000	\$440,000	\$450,000	\$460,000	\$470,000	\$480,000	\$490,000	\$500,000
Age												
< 25	\$16.77	\$17.20	\$17.63	\$18.06	\$18.49	\$18.92	\$19.35	\$19.78	\$20.21	\$20.64	\$21.07	\$21.50
25-29	\$19.89	\$20.40	\$20.91	\$21.42	\$21.93	\$22.44	\$22.95	\$23.46	\$23.97	\$24.48	\$24.99	\$25.50
30-34	\$26.52	\$27.20	\$27.88	\$28.56	\$29.24	\$29.92	\$30.60	\$31.28	\$31.96	\$32.64	\$33.32	\$34.00
35-39	\$30.03	\$30.80	\$31.57	\$32.34	\$33.11	\$33.88	\$34.65	\$35.42	\$36.19	\$36.96	\$37.73	\$38.50
40-44	\$33.54	\$34.40	\$35.26	\$36.12	\$36.98	\$37.84	\$38.70	\$39.56	\$40.42	\$41.28	\$42.14	\$43.00
45-49	\$50.31	\$51.60	\$52.89	\$54.18	\$55.47	\$56.76	\$58.05	\$59.34	\$60.63	\$61.92	\$63.21	\$64.50
50-54	\$73.32	\$75.20	\$77.08	\$78.96	\$80.84	\$82.72	\$84.60	\$86.48	\$88.36	\$90.24	\$92.12	\$94.00
55-59	\$140.01	\$143.60	\$147.19	\$150.78	\$154.37	\$157.96	\$161.55	\$165.14	\$168.73	\$172.32	\$175.91	\$179.50
60-64	\$213.33	\$218.80	\$224.27	\$229.74	\$235.21	\$240.68	\$246.15	\$251.62	\$257.09	\$262.56	\$268.03	\$273.50
65-69	\$413.40	\$424.00	\$434.60	\$445.20	\$455.80	\$466.40	\$477.00	\$487.60	\$498.20	\$508.80	\$519.40	\$530.00
70+	\$690.30	\$708.00	\$725.70	\$743.40	\$761.10	\$778.80	\$796.50	\$814.20	\$831.90	\$849.60	\$867.30	\$885.00

Rates may change as the insured enters a higher age category. Also, rates may change if plan experience requires a change for all insureds.

Spouse - Dependent Term Life Monthly Cost per Coverage Amount

Coverage is available in increments of \$5,000 to a maximum of \$250,000, not to exceed 50% of your Optional Term Life coverage amount. Refer to the Dependent Term Life section for evidence of insurability details. Initial rates based on age as of effective date of your coverage. Rates will change based on the following age schedule.

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000	\$55,000	\$60,000	\$65,000
Age													
< 25	\$0.22	\$0.43	\$0.65	\$0.86	\$1.08	\$1.29	\$1.51	\$1.72	\$1.94	\$2.15	\$2.37	\$2.58	\$2.80
25-29	\$0.26	\$0.51	\$0.77	\$1.02	\$1.28	\$1.53	\$1.79	\$2.04	\$2.30	\$2.55	\$2.81	\$3.06	\$3.32
30-34	\$0.34	\$0.68	\$1.02	\$1.36	\$1.70	\$2.04	\$2.38	\$2.72	\$3.06	\$3.40	\$3.74	\$4.08	\$4.42
35-39	\$0.39	\$0.77	\$1.16	\$1.54	\$1.93	\$2.31	\$2.70	\$3.08	\$3.47	\$3.85	\$4.24	\$4.62	\$5.01
40-44	\$0.43	\$0.86	\$1.29	\$1.72	\$2.15	\$2.58	\$3.01	\$3.44	\$3.87	\$4.30	\$4.73	\$5.16	\$5.59
45-49	\$0.65	\$1.29	\$1.94	\$2.58	\$3.23	\$3.87	\$4.52	\$5.16	\$5.81	\$6.45	\$7.10	\$7.74	\$8.39
50-54	\$0.94	\$1.88	\$2.82	\$3.76	\$4.70	\$5.64	\$6.58	\$7.52	\$8.46	\$9.40	\$10.34	\$11.28	\$12.22
55-59	\$1.80	\$3.59	\$5.39	\$7.18	\$8.98	\$10.77	\$12.57	\$14.36	\$16.16	\$17.95	\$19.75	\$21.54	\$23.34
60-64	\$2.74	\$5.47	\$8.21	\$10.94	\$13.68	\$16.41	\$19.15	\$21.88	\$24.62	\$27.35	\$30.09	\$32.82	\$35.56
65-69	\$5.30	\$10.60	\$15.90	\$21.20	\$26.50	\$31.80	\$37.10	\$42.40	\$47.70	\$53.00	\$58.30	\$63.60	\$68.90
70+	\$8.85	\$17.70	\$26.55	\$35.40	\$44.25	\$53.10	\$61.95	\$70.80	\$79.65	\$88.50	\$97.35	\$106.20	\$115.05

	\$70,000	\$75,000	\$80,000	\$85,000	\$90,000	\$95,000	\$100,000	\$105,000	\$110,000	\$115,000	\$120,000	\$125,000	\$130,000
Age													
< 25	\$3.01	\$3.23	\$3.44	\$3.66	\$3.87	\$4.09	\$4.30	\$4.52	\$4.73	\$4.95	\$5.16	\$5.38	\$5.59
25-29	\$3.57	\$3.83	\$4.08	\$4.34	\$4.59	\$4.85	\$5.10	\$5.36	\$5.61	\$5.87	\$6.12	\$6.38	\$6.63
30-34	\$4.76	\$5.10	\$5.44	\$5.78	\$6.12	\$6.46	\$6.80	\$7.14	\$7.48	\$7.82	\$8.16	\$8.50	\$8.84
35-39	\$5.39	\$5.78	\$6.16	\$6.55	\$6.93	\$7.32	\$7.70	\$8.09	\$8.47	\$8.86	\$9.24	\$9.63	\$10.01
40-44	\$6.02	\$6.45	\$6.88	\$7.31	\$7.74	\$8.17	\$8.60	\$9.03	\$9.46	\$9.89	\$10.32	\$10.75	\$11.18
45-49	\$9.03	\$9.68	\$10.32	\$10.97	\$11.61	\$12.26	\$12.90	\$13.55	\$14.19	\$14.84	\$15.48	\$16.13	\$16.77
50-54	\$13.16	\$14.10	\$15.04	\$15.98	\$16.92	\$17.86	\$18.80	\$19.74	\$20.68	\$21.62	\$22.56	\$23.50	\$24.44
55-59	\$25.13	\$26.93	\$28.72	\$30.52	\$32.31	\$34.11	\$35.90	\$37.70	\$39.49	\$41.29	\$43.08	\$44.88	\$46.67
60-64	\$38.29	\$41.03	\$43.76	\$46.50	\$49.23	\$51.97	\$54.70	\$57.44	\$60.17	\$62.91	\$65.64	\$68.38	\$71.11
65-69	\$74.20	\$79.50	\$84.80	\$90.10	\$95.40	\$100.70	\$106.00	\$111.30	\$116.60	\$121.90	\$127.20	\$132.50	\$137.80
70+	\$123.90	\$132.75	\$141.60	\$150.45	\$159.30	\$168.15	\$177.00	\$185.85	\$194.70	\$203.55	\$212.40	\$221.25	\$230.10

	\$135,000	\$140,000	\$145,000	\$150,000	\$155,000	\$160,000	\$165,000	\$170,000	\$175,000	\$180,000	\$185,000	\$190,000
Age												
< 25	\$5.81	\$6.02	\$6.24	\$6.45	\$6.67	\$6.88	\$7.10	\$7.31	\$7.53	\$7.74	\$7.96	\$8.17
25-29	\$6.89	\$7.14	\$7.40	\$7.65	\$7.91	\$8.16	\$8.42	\$8.67	\$8.93	\$9.18	\$9.44	\$9.69
30-34	\$9.18	\$9.52	\$9.86	\$10.20	\$10.54	\$10.88	\$11.22	\$11.56	\$11.90	\$12.24	\$12.58	\$12.92
35-39	\$10.40	\$10.78	\$11.17	\$11.55	\$11.94	\$12.32	\$12.71	\$13.09	\$13.48	\$13.86	\$14.25	\$14.63
40-44	\$11.61	\$12.04	\$12.47	\$12.90	\$13.33	\$13.76	\$14.19	\$14.62	\$15.05	\$15.48	\$15.91	\$16.34
45-49	\$17.42	\$18.06	\$18.71	\$19.35	\$20.00	\$20.64	\$21.29	\$21.93	\$22.58	\$23.22	\$23.87	\$24.51
50-54	\$25.38	\$26.32	\$27.26	\$28.20	\$29.14	\$30.08	\$31.02	\$31.96	\$32.90	\$33.84	\$34.78	\$35.72
55-59	\$48.47	\$50.26	\$52.06	\$53.85	\$55.65	\$57.44	\$59.24	\$61.03	\$62.83	\$64.62	\$66.42	\$68.21
60-64	\$73.85	\$76.58	\$79.32	\$82.05	\$84.79	\$87.52	\$90.26	\$92.99	\$95.73	\$98.46	\$101.20	\$103.93
65-69	\$143.10	\$148.40	\$153.70	\$159.00	\$164.30	\$169.60	\$174.90	\$180.20	\$185.50	\$190.80	\$196.10	\$201.40
70+	\$238.95	\$247.80	\$256.65	\$265.50	\$274.35	\$283.20	\$292.05	\$300.90	\$309.75	\$318.60	\$327.45	\$336.30

Spouse - Dependent Term Life Monthly Cost per Coverage Amount

Coverage is available in increments of \$5,000 to a maximum of \$250,000, not to exceed 50% of your Optional Term Life coverage amount. Refer to the Dependent Term Life section for evidence of insurability details. Initial rates based on age as of effective date of your coverage. Rates will change based on the following age schedule.

	\$195,000	\$200,000	\$205,000	\$210,000	\$215,000	\$220,000	\$225,000	\$230,000	\$235,000	\$240,000	\$245,000	\$250,000
Age												
< 25	\$8.39	\$8.60	\$8.82	\$9.03	\$9.25	\$9.46	\$9.68	\$9.89	\$10.11	\$10.32	\$10.54	\$10.75
25-29	\$9.95	\$10.20	\$10.46	\$10.71	\$10.97	\$11.22	\$11.48	\$11.73	\$11.99	\$12.24	\$12.50	\$12.75
30-34	\$13.26	\$13.60	\$13.94	\$14.28	\$14.62	\$14.96	\$15.30	\$15.64	\$15.98	\$16.32	\$16.66	\$17.00
35-39	\$15.02	\$15.40	\$15.79	\$16.17	\$16.56	\$16.94	\$17.33	\$17.71	\$18.10	\$18.48	\$18.87	\$19.25
40-44	\$16.77	\$17.20	\$17.63	\$18.06	\$18.49	\$18.92	\$19.35	\$19.78	\$20.21	\$20.64	\$21.07	\$21.50
45-49	\$25.16	\$25.80	\$26.45	\$27.09	\$27.74	\$28.38	\$29.03	\$29.67	\$30.32	\$30.96	\$31.61	\$32.25
50-54	\$36.66	\$37.60	\$38.54	\$39.48	\$40.42	\$41.36	\$42.30	\$43.24	\$44.18	\$45.12	\$46.06	\$47.00
55-59	\$70.01	\$71.80	\$73.60	\$75.39	\$77.19	\$78.98	\$80.78	\$82.57	\$84.37	\$86.16	\$87.96	\$89.75
60-64	\$106.67	\$109.40	\$112.14	\$114.87	\$117.61	\$120.34	\$123.08	\$125.81	\$128.55	\$131.28	\$134.02	\$136.75
65-69	\$206.70	\$212.00	\$217.30	\$222.60	\$227.90	\$233.20	\$238.50	\$243.80	\$249.10	\$254.40	\$259.70	\$265.00
70+	\$345.15	\$354.00	\$362.85	\$371.70	\$380.55	\$389.40	\$398.25	\$407.10	\$415.95	\$424.80	\$433.65	\$442.50

Rates may change as the insured enters a higher age category. Also, rates may change if plan experience requires a change for all insureds.

Spouse rate is based on employee's age.

Children - Dependent Term Life Monthly Cost per Coverage Amount

One premium rate covers all eligible children

Coverage is available for \$10,000, not to exceed 50% of your Optional Term Life coverage amount.

\$10,000

\$1.00

Rates may change if plan experience requires a change for all insureds.

Employee - Optional Accidental Death & Dismemberment Monthly Cost per Coverage Amount

Your Optional AD&D coverage amount is equal to your Optional Term Life coverage amount. Refer to the Optional AD&D section for evidence of insurability details.

\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
\$0.10	\$0.20	\$0.30	\$0.40	\$0.50	\$0.60	\$0.70	\$0.80	\$0.90	\$1.00

Spouse - Optional Accidental Death & Dismemberment Monthly Cost per Coverage Amount

Your Optional AD&D coverage amount for your spouse is equal to your spouse's Dependent Term Life coverage amount. Refer to the Optional AD&D section for evidence of insurability details.

\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000	\$55,000	\$60,000	\$65,000
\$0.05	\$0.10	\$0.15	\$0.20	\$0.25	\$0.30	\$0.35	\$0.40	\$0.45	\$0.50	\$0.55	\$0.60	\$0.65
\$70,000	\$75,000	\$80,000	\$85,000	\$90,000	\$95,000	\$100,000	\$105,000	\$110,000	\$115,000	\$120,000	\$125,000	\$130,000
\$0.70	\$0.75	\$0.80	\$0.85	\$0.90	\$0.95	\$1.00	\$1.05	\$1.10	\$1.15	\$1.20	\$1.25	\$1.30

Spouse - Optional Accidental Death & Dismemberment Monthly Cost per Coverage Amount

Your Optional AD&D coverage amount for your spouse is equal to your spouse's Dependent Term Life coverage amount. Refer to the Optional AD&D section for evidence of insurability details.

\$135,000	\$140,000	\$145,000	\$150,000	\$155,000	\$160,000	\$165,000	\$170,000	\$175,000	\$180,000	\$185,000	\$190,000
\$1.35	\$1.40	\$1.45	\$1.50	\$1.55	\$1.60	\$1.65	\$1.70	\$1.75	\$1.80	\$1.85	\$1.90
\$195,000	\$200,000	\$205,000	\$210,000	\$215,000	\$220,000	\$225,000	\$230,000	\$235,000	\$240,000	\$245,000	\$250,000
\$1.95	\$2.00	\$2.05	\$2.10	\$2.15	\$2.20	\$2.25	\$2.30	\$2.35	\$2.40	\$2.45	\$2.50

Children - Optional Accidental Death & Dismemberment Monthly Cost per Coverage Amount

One premium rate covers all eligible children

Your Optional AD&D coverage amount for your child(ren) is equal to your child(ren)'s Dependent Term Life coverage amount. Refer to the Optional AD&D section for evidence of insurability details.

\$10,000

\$0.10

Benefits, exclusions and provisions may vary by state. Refer to the plan booklet for details.

For your coverage to become effective, you must be actively at work on the effective date of the plan. If you apply for an amount that requires satisfactory evidence of insurability to The Prudential Insurance Company of America, you must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

*Accelerated Death Benefit option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered "terminally ill" or "chronically ill." You may wish to seek professional tax advice before exercising this option.

This coverage is not health insurance coverage (often referred to as "Major Medical Coverage").

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

IMPORTANT NOTICE - THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Group Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ 07102. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply. Contract Series: 83500

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GESA CREDIT UNION FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

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**XI
SUMMARY**

GESA CREDIT UNION FLEXIBLE BENEFITS PLAN

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan.

II OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance unless you elect, during the election period (defined below), not to participate in the Plan.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Day Care Flexible Spending Arrangement, then there is a change in status if your dependent no longer meets the qualifications to be eligible for Day Care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Care Flexible Spending Arrangement, and you may not change your election to the Health Care Flexible Spending Arrangement if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Day Care Flexible Spending Arrangement if the cost change is imposed by a Day Care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Employer sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

IV BENEFITS

1. Health Care Flexible Spending Arrangement

The Health Care Flexible Spending Arrangement enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Care Flexible Spending Arrangement allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

However, if you participate in a HSA, you can only be reimbursed by the Employer for out-of-pocket dental, vision or preventive care expenses incurred by you and your dependents.

If you are a HSA participant, drug costs, including insulin, may be reimbursed if they are considered for dental, vision or preventive care expenses.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

For 2020, the most you can contribute is \$2,750. After 2020, the dollar limit may increase for cost of living adjustments. The minimum amount that you may contribute to the Health Care Flexible Spending Arrangement each Plan Year is \$50. In addition, you will be eligible to carryover amounts left in your Health Care Flexible Spending Arrangement, up to \$500. This

means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans 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, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

2. Day Care Flexible Spending Arrangement

The Day Care Flexible Spending Arrangement enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Day Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Day Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the Day Care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Day Care Flexible Spending Arrangement. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain Day Care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Day Care Flexible Spending Arrangement under our Plan. Ask your tax adviser which is better for you.

3. Premium Conversion Benefit

A Premium Conversion Benefit allows you to use tax-free dollars to pay for certain premiums under various insurance programs that we offer you. These premiums include:

- Health care premiums under our insured group medical plan.

- Group term life insurance premiums.
- Dental insurance premiums.
- Disability insurance premiums.
- Vision insurance premiums.
- Accidental death and dismemberment insurance premiums.
- Prescription drug coverage.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

4. May I direct Plan contributions to my Health Savings Account?

Yes. Any monies that you do not apply toward available benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by our insured medical plan and save taxes at the same time. Please see your Plan Administrator for further details.

V BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Day Care Flexible Spending Arrangement to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited, except for \$500 that can be carried over into the next Plan Year for the Health Care Flexible Spending Arrangement or, except for amounts contributed to your Health Savings Account. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. For the Day Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance, group-term life insurance and the Health Care Flexible Spending Arrangement. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Flexible Spending Arrangement, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect

\$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Care Flexible Spending Arrangement are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Flexible Spending Arrangement under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying Day Care expenses incurred during the remainder of the Plan Year from the balance remaining in your Day Care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.

(c) Your Health Savings Account amounts will remain yours even after your termination of employment.

(d) For health benefit coverage and Health Care Flexible Spending Arrangement coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Care Flexible Spending Arrangement will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Care Flexible Spending Arrangement have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

**VII
PLAN ACCOUNTING**

1. Plan Balances

The Administrator will provide you with the ability to view your account balance online anytime during the Plan Year that shows your account balance. It is important review this information periodically so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

**VIII
GENERAL INFORMATION ABOUT OUR PLAN**

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Gesa Credit Union Flexible Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on January 1, 2020. Your Plan was originally effective on January 1, 2010.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Gesa Credit Union
51 Gage Blvd, PO Box 500
Richland, Washington 99352
91-0616262

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Gesa Credit Union
51 Gage Blvd, PO Box 500
Richland, Washington 99352
(509) 946-1611

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Gesa Credit Union
51 Gage Blvd, PO Box 500
Richland, Washington 99352

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

IX ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;
- (c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and
- (d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a 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.

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 Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are 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 are successful, the court may order the person you have 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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. For the Day Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a Claim under the Plan is denied in whole or in part, you will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. .

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal. You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Employer. You must submit a request for a level two appeal within 60 days of receipt of the level one notice. You will be notified within 30 days after the Employer receives the appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate plan provisions. Decisions of the Employer are conclusive and binding.

In the case of a claim under Flexible Spending Arrangement, the following timetable for claims applies:

Notification of whether claim is accepted or denied: 30 days

Extension due to matters beyond the control of the Plan: 15 days

Denial or insufficient information on the claim:

Notification of: 15 days

Response by Participant: 45 days

Review of claim denial: 30 days

You must file your appeal by submitting a written request by email, fax, or mail. Indicate either level one or level two appeal on the email, fax, or letter.

Email: claims@naviabenefits.com

Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 60 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

X CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Care Flexible Spending Arrangement.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to

COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.
- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.
- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.
- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its

designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,
- (b) death of the employee,
- (c) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (d) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Gesa Credit Union
51 Gage Blvd, PO Box 500
Richland, Washington 99352

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of

coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (a) The last day of the applicable maximum coverage period.
- (b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- (e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
 - (1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
 - (2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

18. How is my participation in the Health Care Flexible Spending Arrangement affected?

You can elect to continue your participation in the Health Care Flexible Spending Arrangement for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Flexible Spending Arrangement if you have elected to contribute more money including any carryover amounts than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Care Flexible Spending Arrangement. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

XI SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

APPENDIX I TO THE FLEXIBLE SPENDING ARRANGEMENT SUMMARY PLAN DESCRIPTION

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PHI ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

EFFECTIVE DATE OF THE PLAN

This Notice of Privacy Practices (“Notice”) describes the legal obligations of the Plan and your rights regarding your protected health information (“PHI”) held by the Flexible Spending Arrangement Plan (the “Plan”). PHI is defined by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). PHI generally means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased.

This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes permitted or required by law.

We are required by law to:

- maintain the privacy of your PHI;
- provide you with the notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of the Notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer who assist in administration of the Plan. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. Employer will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

Employer may not use or disclose your PHI other than as summarized herein or as required by law. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE YOUR PHI

The following categories describe different ways that we use and disclose PHI for purposes of Plan administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations) We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations) We may use and disclose PHI about you for other Plan operations. These uses and disclosures are necessary to administer the Plan.

To Business Associates, Subcontractors, Brokers, and Agents We may contract with entities known as Business Associates to perform various functions on the Plan’s behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing to implement appropriate safeguards regarding your PHI in a Business Associate Agreement. Our Business Associates shall also require each of its subcontractors or agents to agree in writing to provisions that impose at least the same obligations to protect PHI as are imposed on Business Associate by the Business Associate Agreement or by HIPAA.

As Required By Law We will disclose PHI about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Disclosure to Health Plan Sponsor Information may be disclosed to another health plan maintained by Employer for

purposes of facilitating claims payments under that plan. In addition, PHI may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.

SPECIAL SITUATIONS

Organ and Tissue Donation If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

Workers' Compensation We may release PHI about you for workers' compensation or similar programs.

Public Health Risks We may disclose PHI about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities We may disclose PHI to a health oversight agency for activities authorized by law.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors We may release PHI to a coroner or medical examiner. We may also release PHI about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official.

Research We may disclose your PHI for research if the individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

REQUIRED DISCLOSURES

Government Audits We are required to disclose your PHI to Health and Human Services ("HHS") in the event of an audit in order to determine our compliance with HIPAA.

Disclosures to you We are required to disclose your PHI to you. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for treatment, payment, or health care operations, and if the PHI was not disclosed pursuant to your authorization.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI:

Right to Inspect and Copy You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to your Human Resources Department. If the information you request is in electronic copy, and you request an electronic copy, we will provide a copy in electronic format unless the information cannot be readily produced in that format then we will work with you to come to an agreement on a different format. If we cannot agree, we will provide you with a paper copy.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

In certain very limited circumstances, we may deny your request to inspect and copy. If you are denied access to PHI, you may request that the denial be reviewed by your Human Resources Department.

Right to Amend If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to your Human Resources Department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the PHI kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to Receive Notice of Breach You have a right to be notified upon a breach of your unsecured PHI.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures" of PHI made in the six years prior to the date on which the accounting is requested, except for disclosures:

- To carry out treatment, payment and health care operations as provided in §164.506;
- To individuals of PHI about them as provided in §164.502;
- Incident to a use or disclosure otherwise permitted;
- Pursuant to an authorization as provided in §164.508;
- to persons involved in the individual's care or other notification purposes as provided in §164.510;
- For national security or intelligence purposes as provided in §164.512(k)(2);
- To correctional institutions or law enforcement officials as provided in §164.512(k)(5);
- As part of a limited data set in accordance with §164.514(e); or
- That occurred prior to the compliance date for the Plan.

Please submit a written request of an accounting of disclosures to your Human Resources Department.

Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular claim with your spouse. To request a restriction, you must make your request, in writing, to your Human Resources Department. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid the health care provider "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications You have the right to request that we communicate with you about your PHI a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to your Human Resources Department. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy You have a right to a paper copy of this Notice. You may ask for a copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. Contact the Human Resources Department for a paper copy of this Notice.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this Notice of Privacy Practices that may be provided to you. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. The Notice will indicate the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of HHS. To file a complaint with the Plan, contact your Human Resources Department. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with an authorization to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization and that we are required to retain our records of the care that we provided to you.

Authorizations for Psychiatric Notes, Genetic Information, Marketing, & Sale In general, and subject to specific conditions, we will not use or disclose psychiatric notes without your authorization; we will not use or disclose PHI that is genetic information for underwriting purposes; we will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; we will not use your PHI for marketing purposes without your authorization; and we will not use or disclose your PHI for fundraising purposes unless we disclose that activity in this Notice.

Personal Representatives We may disclose your PHI to individuals authorized by you, or an individual designated as your personal representative, provided that we have received your authorization or some other Notice or documentation demonstrating the legal right of that individual to receive such information. Under HIPAA we do not have to disclose PHI to a personal representative if we have a reasonable belief that:

- 1) you have been or may be subjected to domestic violence, abuse, or neglect by such person; or
- 2) treating such person as your personal representative could endanger you; and
- 3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and other Family Members With only limited exceptions, we will send all mail to the employee. This may include information regarding a spouse or dependents also covered under the Plan. Information includes, but is not limited to, Plan statements, benefit denials, and benefit debit cards and accompanying information.

Gesa Credit Union

Gesa Credit Union
PO Box 500
Richland, WA 99352

Gesa Credit Union HRA Plan

Summary Plan Description

Effective January 01, 2021

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INTRODUCTION

This is the Summary Plan Description (the "SPD") for the Gesa Credit Union HRA Plan, a Health Reimbursement Arrangement (the "HRA"). This SPD summarizes your rights and obligations as a participant (or beneficiary) in the HRA.

Read this SPD carefully so that you understand the provisions of our HRA and the benefits you will receive. You should direct any questions you have to the Plan Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this SPD and the plan document, the plan document will control.

I. ELIGIBILITY

01. What Are the Eligibility Requirements for this HRA?

You will be automatically enrolled in the HRA when you enroll in the Employer's group medical plan, unless you have opted out of the HRA.

02. When is My Entry Date?

Your entry date is the date you satisfy the eligibility requirements of and enroll in the Employer's group medical plan.

03. Are There Any Employees Who Are Not Eligible?

Yes, employees who are not eligible to receive medical benefits under the group medical plan, or who are not enrolled in that plan, are not eligible to join the HRA.

II. BENEFITS

01. What Benefits Are Available?

The HRA allows for reimbursement for expenses as described in the Appendices of this document. The expenses that qualify are those permitted by Section 213(d) of the Internal Revenue Code.

The amounts provided to the HRA by your employer will be made available on the first day of the plan year.

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Any amounts reimbursed under the HRA may not be claimed as a deduction on your personal income tax return or reimbursed by other health plan coverage.

If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, refer to Appendix A for information on how these funds will be handled.

02. What is the "Plan Year"?

The "Plan Year" begins January 01 and ends December 31.

03. What is the "Coverage Period"?

The period of the current "Coverage Period" in which the individual is an eligible employee on or after his or her plan entry date.

04. How are payments made from the HRA?

You may submit requests for reimbursement of expenses you have incurred during the course of a Coverage Period in accordance with the instructions of the Plan Administrator. The Plan Administrator will provide you with further details. However, you must make your requests for reimbursements no later than 90 days after the end of the Coverage Period (that is, no later than 03/31). In addition, you must submit to the Plan Administrator, in accordance with the instructions of the Plan Administrator, proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the HRA has agreed to pay, you will receive a reimbursement payment soon thereafter.

Remember, reimbursements made from the HRA are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

05. What Happens If I Terminate Employment?

If your employment is terminated during the Plan Year for any reason, your participation in the HRA will cease on the date of your termination, and you will not be eligible to be reimbursed for any expenses incurred past that date. You must submit claims for any expenses incurred prior to your termination of employment within 90 days after you terminate employment. Any unused amounts will be forfeited.

06. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage under these benefits terminates, due to your revocation of the benefits or non-payment of contributions while on leave, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

07. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, the Uniformed Services Employment and Reemployment Rights Act of 1994 may give you special rights to health care coverage under the HRA. These rights can include extended health care coverage. USERRA continuation coverage is concurrent with COBRA continuation coverage. If you may be affected by this law, ask your Plan Administrator for further details.

08. Newborn and Mothers Health Protection Act

Group health plans 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, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the HRA or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

09. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is

determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

III. GENERAL INFORMATION ABOUT OUR HRA

This Section contains certain general information, which you may need to know about the HRA.

01. General HRA Information

"Gesa Credit Union HRA Plan" is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The company has adopted this Plan effective January 01, 2021.

Your Plan's records are maintained on the basis of a period of time known as the "Plan Year." The Plan Year begins on January 01 and ends December 31 (the "Plan Year").

02. Employer Information

Your Employer's name, address, and identification number are:

Gesa Credit Union
PO Box 500
Richland, WA 99352
EIN: 91-0616262

03. Plan Administrator Information

The name and address of your Plan Administrator are:

Gesa Credit Union
PO Box 500
Richland, WA 99352

The Plan Administrator will also answer any questions you may have about our HRA. The Plan Administrator has the exclusive right to interpret the appropriate HRA provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Plan Administrator for any further information about the HRA.

04. Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the HRA. The HRA Agent of Service is:

Gesa Credit Union
PO Box 500
Richland, WA 99352

Legal process may also be served on the Plan Administrator.

05. Type of Administration

The HRA is a health reimbursement arrangement. The HRA is not funded or insured. Benefits are paid from the general assets of the Employer.

06. Claims Administrator Information

The name and address of your Claims Administrator are:

Navia Benefit Solutions
PO Box 53250
Bellevue, WA 98015

The Claims Administrator keeps the claims records for the HRA and is responsible for the claims administration of the HRA. The Claims Administrator will also answer any claims-related questions you may have about the HRA.

IV. ADDITIONAL HRA INFORMATION

01. Your Rights Under ERISA

HRA Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- a. Examine, without charge, at the Plan Administrator's office, all HRA documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the HRA with the U.S. Department of Labor (also, available at the Public Disclosure Room of the Employee Benefits Security Administration).
- b. Obtain copies of all HRA documents and other HRA information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.
- c. Continue health care coverage for a HRA Participant, Spouse, or other dependents if there is a loss of coverage under the HRA as a result of a qualifying event. Employees and dependents may have to pay for such coverage.
- d. Review this Summary Plan Description and the documents governing the HRA on the rules governing COBRA continuation coverage rights.

If your claim for a 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 frames.

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; provided, such suit may be filed only after the plan's review procedures described herein have been exhausted and only if filed within 90 days after the final decision on review is provided, or, if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, only if filed by such later date.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the HRA and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to \$112 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 a HRA Participant disagrees with the HRA's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for HRA Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the HRA. The individuals who operate the HRA, called "fiduciaries" of the HRA, have a duty to do so prudently and in the interests of the HRA Participants and their beneficiaries. No one, including the Employer or any other person, may fire a HRA Participant or otherwise discriminate against a HRA Participant in any way to prevent the HRA Participant from obtaining benefits under the HRA or from exercising his or her rights under ERISA.

If it should happen that HRA fiduciaries misuse the HRA's money, or if you are 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 are successful, the court may order the person you have 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.

If you have any questions about the HRA, you should contact the Plan Administrator. If you have any questions about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, 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.

02. How claims are submitted

When you have a Claim to submit for payment, you must:

1. File the claim in accordance with the instructions of the Plan Administrator.
2. Submit copies of all supporting receipts and/or Explanation of Benefits (EOB) from your insurance carrier for which you are requesting reimbursement.

A Claim is defined as any request for a HRA benefit, made by a claimant or by a representative of a claimant that complies with the HRA's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Unless otherwise specified, decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Claims Administrator will provide written or electronic notification of any Claim denial. The notice will state:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific HRA or Welfare Program provisions on which the determination is based.
4. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
5. A description of the HRA's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal.
6. Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.
7. In the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.
8. The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision to the Claims Administrator. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the HRA. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the Claim determination;
2. was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with HRA documents and HRA provisions have been applied consistently with respect to all claimants;
4. or constituted a statement of policy or guidance with respect to the HRA concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the HRA who is neither the individual who made the adverse determination nor a subordinate of that individual.

After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the HRA a request for an external review. A claimant may request from the Plan Administrator additional information describing the HRA's external review procedure.

V. CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this HRA will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the HRA would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA. The HRA itself can provide group health benefits and may also be used to provide health benefits through insurance.

01. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

02. Are there other coverage options?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace, which coverage began effective January 1, 2014. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

03. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under the HRA by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the HRA under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the HRA as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the HRA under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the HRA due to his or her performance of services for the employer sponsoring the HRA. However, this provision does not establish eligibility of these individuals. Eligibility for HRA coverage shall be determined in accordance with HRA Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

04. What is a Qualifying Event?

A Qualifying Event is any of the following if the Arrangement provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's HRA coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A covered Employee's enrollment in any part of the Medicare program.
5. A Dependent child's ceasing to satisfy the HRA's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the HRA under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the HRA occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the HRA that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the HRA provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the HRA during the FMLA leave.

05. What Factors Should Be Considered When Determining to Elect COBRA Continuation Coverage?

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after HRA coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under "Are there other coverage options?" for more information on your options for Marketplace coverage.

06. Election for Obtaining COBRA Continuation Coverage?

The HRA has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

07. What is the Election Period and How Long Does It Last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the HRA. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

08. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The HRA will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. the death of the employee,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or enrollment of the employee in any part of Medicare.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Gesa Credit Union
PO Box 500
Richland, WA 99352

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the Qualifying event that coverage would otherwise have been lost. The COBRA period begins on the date of the Qualifying Event, even though coverage actually ends at the end of the month. If you or your Spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

09. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

10. Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health HRA Coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

11. When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and

ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Arrangement with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other HRA that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - b. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The HRA can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the HRA can terminate for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the HRA solely because of the individual's relationship to a Qualified Beneficiary, if the HRA's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the HRA is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

12. What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

13. Under What Circumstances Can the Maximum Coverage Period Be Extended?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is extended to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be extended to more than 36-months after the date of the first Qualifying Event.

The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

14. How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the HRA Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

15. Does the HRA Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the HRA, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any extended period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

16. Must the HRA Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?

Yes. The health coverage is also permitted to allow for payment at other intervals.

17. What is Timely Payment for COBRA Continuation Coverage?

"Timely Payment" means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the HRA on a later date is also considered Timely Payment if either (i) under the terms of the HRA covered employees or Qualified Beneficiaries are allowed to pay for their coverage for the period on that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides benefits on the Employer's behalf the Employer is allowed to pay for coverage of similarly situated non-COBRA beneficiaries for the period on that later date.

Notwithstanding the above paragraph, the HRA does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the HRA.

If Timely Payment is made to the HRA in an amount that is not significantly less than the amount the HRA requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the HRA's requirement for the amount to be paid, unless the HRA notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

18. Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health HRA at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the HRA will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the HRA. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee.

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Appendix A - HRA Plan Benefit

HRA PLAN 1 – Employee Only

Employee Class

- Employee Only

Qualified benefits

- Deductible - Medical

Plan Coverage

- Medical

Reimbursement Schedule

- First, the Employee will pay 100.00% up to \$2,500.00 of qualifying expenses.
- Last, the HRA will pay 100.00% up to \$2,500.00 of qualifying expenses up to a max benefit limit of \$2,500.00.

Unused HRA Funds

- Unused benefits at the end of the coverage period shall be forfeited.

Appendix A - HRA Plan Benefit

HRA PLAN 2 – Employee + Family

Employee Class

- Family

Qualified benefits

- Deductible - Medical

Plan Coverage

- Medical

Reimbursement Schedule

- First, the Employee will pay 100.00% up to \$2,800.00 of qualifying expenses.
- Last, the HRA will pay 100.00% up to \$2,200.00 of qualifying expenses up to a max benefit limit of \$5,000.00.

Unused HRA Funds

- Unused benefits at the end of the coverage period shall be forfeited.

Embedded Minimums

- Those enrolled in an employee + one or more dependents level of coverage (family coverage) on the Qualified High Deductible Health Plan (QHDHP) will each be reimbursed based on embedded individual deductibles (\$5,000 individual/\$10,000 family). In order to begin submitting for reimbursement from the HRA, either one person on the plan must meet \$2,800 of the \$5,000 (individual) deductible or two or more family members need to collectively meet \$5,000 of the \$10,000 (family) deductible. The HRA family out-of-pocket maximum is \$5,000. For employees with family coverage, each enrolled family member is responsible for satisfying \$2,800 in deductible expenses before the HRA kicks in and pays 100% of the next \$2,200. Once the family has collectively satisfied \$5,000 in deductible expenses, all family members will move to the next tier and each family member's claims will be paid at 100% until the family has reached the maximum HRA reimbursement of \$5,000.

Appendix B

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a Claim under the Plan is denied in whole or in part, you will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure.

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal (for example, your original claim, denial, claim documentation, and other correspondence or records). You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Employer. You must submit a request for a level two appeal within 60 days of receipt of the level one denial notice. You will be notified within 30 days after the Employer receives the level two appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate plan provisions. Decisions of the Employer are conclusive and binding.

In the case of a claim under the Plan, the following timetable for claims applies:

Notification of whether claim is accepted or denied: 30 days

Extension due to matters beyond the control of the Plan: 15 days

Denial or insufficient information on the claim:

Notification of: 15 days

Response by Participant: 45 days

Review of claim denial: 30 days

You must file your level one appeal by submitting a written request by email, fax, or mail. Indicate level one appeal on the email, fax, or letter. You must submit a level one appeal before you can submit a level two appeal. For the **level one appeal** submit to:

Email: claims@naviabenefits.com

Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review (if applicable);

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

If your level one appeal is denied, you will have 60 days following receipt of the denial notification in which to appeal the decision in a level two appeal to your employer. You may submit written comments, documents, records, and other information relating to the claim (for example, your level one appeal, the original claim, denial, claim documentation, and other correspondence or records). If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

You must file your level two appeal by submitting a written request by email, fax, or mail. Indicate level two appeal on the email, fax, or letter. For the **level two appeal** submit to:

Email: claims@naviabenefits.com

Fax: 425-451-7002 or 866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The level two appeal review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual. If applicable to your plan, you may have a right to bring a civil action under ERISA § 502(a) if you file a level two appeal and your request for benefits is denied.

A LOOK AT YOUR VSP VISION COVERAGE



SEE HEALTHY AND LIVE HAPPY WITH HELP FROM GESA CREDIT UNION AND VSP.



As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.



Like shopping online? Go to **eyeconic.com** and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA \$20 +
TO SPEND ON
FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON
LACOSTE   NINE WEST

SEE MORE BRANDS AT [VSP.COM/OFFERS](https://vsp.com/offers).

UP
TO **40%**
SAVINGS ON LENS
ENHANCEMENTS



Contact us: **800.877.7195** or vsp.com

YOUR VSP VISION BENEFITS SUMMARY

GESA CREDIT UNION and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

01/01/2022



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$0	Every 12 months
PRESCRIPTION GLASSES			
FRAME	<ul style="list-style-type: none"> \$200 featured frame brands allowance \$180 frame allowance 20% savings on the amount over your allowance \$180 Walmart®/Sam's Club® frame allowance \$100 Costco® frame allowance 	\$0	Every 24 months
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children 	\$0	Every 12 months
LENS ENHANCEMENTS	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 30% on other lens enhancements 	\$0 \$95 - \$105 \$150 - \$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	<ul style="list-style-type: none"> \$180 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every 12 months
DIABETIC EYECARE PLUS PROGRAMSM	<ul style="list-style-type: none"> Retinal screening for members with diabetes Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details. 	\$0 \$20 per exam	As needed
EXTRA SAVINGS	Glasses and Sunglasses <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. 		
	Routine Retinal Screening <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 		
	Laser Vision Correction <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

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Transparency in Coverage – Machine-Readable Files

Where can Gesa members access in and out-of-network negotiated rates and net prices for medical and RX? The files are posted publicly and Gesa should post these to their public site. These files are not user friendly and Premera advice to educate members on utilizing the cost comparison tool available in each member's account on Premera.com. machine-readable files are posted publicly at S365 MRF Hub (sapphiremrfhub.com). Please note this includes the INN and OON files only.

[S365 MRF Hub \(sapphiremrfhub.com\)](http://sapphiremrfhub.com)