Group Medicare Supplement Certificate Plan F by Reason of Age

P.O. Box 327
Seattle, WA 98111-0327

30-DAY RIGHT TO REVIEW

PLEASE READ this certificate of coverage ("booklet"). It will explain what is and is not covered. After you have read it, if you are not satisfied, send it back to us within 30 days of the day you received it. We will refund your payment within 30 days of our receipt of the booklet, or we will pay an additional 10 percent penalty which will be added to your refund. Your coverage will then be deemed void from its beginning.

SUBSCRIPTION CHARGES

The Group may require you to pay the subscription charges for this plan. Payments are due on or before the first of each month. After the due date, we give you ten extra days, beginning with the due date, in which to make your payment. If you do not pay your subscription charges within the ten extra days, your coverage will end without further notice as of the date through which your coverage was paid. Any claims incurred after that date will not be covered.

Subscription charges are subject to change. Any change will apply to all subscribers in the same class under this plan. We will notify you 30 days before the change.

GUARANTEED RENEWABLE

This plan is guaranteed renewable, upon payment of the subscription charges and continuation of the contract by the Group. It can only be canceled if your subscription charges are not paid, if you lose eligibility for coverage under the Group's plan, or if the Group terminates or replaces this plan. If this should happen, you have the right to continued Medicare supplement coverage as stated in **Conversion Right** in this booklet. Moreover, we can cancel your coverage retroactively for material misrepresentation on your application (See **When Coverage Ends**). If you are aware of any incorrect or incomplete information, you should contact Premera now, before any claim arises.

Group Name:	Washington State Health Care Authority
Contract Effective Date:	January 1, 2024
Plan:	Group Medicare Supplement Plan F (by reason of age) Contract Form
Number:	GMSF65 (01-2024)

NOTICE TO BUYER
This plan may not cover all of your medical expenses.

An Independent Licensee of the Blue Cross Blue Shield Association

ABOUT THIS PLAN

The benefits, limitations, exclusions and other provisions in this booklet are subject to the terms of Premera Blue Cross's contract with the Group named on its Face Page. This booklet is a part of that contract. It replaces any other group Medicare supplement certificate you may have received. This certificate of coverage is an important document and should be kept in a safe place.

The Group has delegated authority to Premera Blue Cross to use its expertise and judgment as part of the routine operation of the plan to reasonably apply the terms of the contract for making decisions as they apply to specific eligibility, benefits and claims situations. This does not prevent you from exercising rights you may have under applicable law to appeal or bring a civil lawsuit challenging any eligibility or claims determinations under the contract, including our exercise of our judgment and expertise.

This plan is delivered in and governed by the laws of Washington. You may not be enrolled in this plan if it duplicates benefits provided under another Medicare Supplement plan or a Medicare Advantage plan.

This plan does not duplicate benefits paid by Medicare. The deductible and coinsurance amounts paid by this plan will automatically change when Medicare’s deductible and coinsurance requirements change.

Kip Haffner

Senior Vice President, Medicare

Premera Blue Cross

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INTRODUCTION

The contract consists of your approved application, this certificate of coverage ("booklet"), the completed and signed Group Master Application, the group contract documents, and any endorsements or riders. (An endorsement is a form signed by an officer of Premera Blue Cross that adds or changes provisions of the contract.)

The following sections of this booklet will be especially helpful to you:

- **How To Contact Us** – Our Web site, phone numbers, mailing addresses and other information is on the back cover of this booklet
- **Benefits** — What this plan covers
- **What This Plan Does Not Cover** — Services and supplies that are either limited or not covered under this plan.
- **How To File A Claim** — Step-by-step instructions on how to send us a claim
- **How To Appeal A Claim Decision** — How you can request us to reconsider our decision on a claim
- **Definitions** — Terms that have specific meanings in this plan. Example: In this booklet, the words **you** and **your** mean the person covered by this plan. Only you are eligible for its benefits. The words **we, us, and our** mean Premera Blue Cross, also referred to as "Premera."

Medicare Resources

You will also find it helpful to refer to 3 pieces of information.

- Medicare's handbook, *Medicare And You*, which explains your Medicare benefits. You can get a copy from the Internet or at any Social Security Office.
- The Outline of Medicare Supplement Coverage that we provide. This is a summary of what Medicare and this plan cover.
- Medicare's *Choosing A Medigap Policy* guide that we provide.

BENEFITS

This Plan And Medicare

- Most of this plan's benefits are based on Medicare-eligible services, supplies and expenses (see **Definitions**). For these benefits to be provided, the services you receive must be provided by facilities and practitioners who are Medicare-eligible as defined in the Medicare program.

  Medicare may, from time to time, change its deductible and coinsurance amounts. When this happens, this plan will automatically cover the changed Medicare deductible and coinsurance amounts applicable to this plan. We will notify you 30 days in advance of any changes Medicare makes that affect your coverage under this plan.
- Only the benefits shown in **Benefits For Expenses Not Covered By Medicare** are available for services or supplies which are not eligible expenses under Medicare Parts A and B. Otherwise, if Medicare doesn't cover a service or supply, neither will this plan.
- Medicare has requirements that must be met for some benefits, such as hospice and skilled nursing facility care. If you don't meet Medicare's requirements and as a result Medicare doesn't cover a service or supply, neither will this plan.
- Medicare has maximums for certain types of services. When you reach Medicare's benefit maximum for a particular type of service, coverage under this plan will also end for that type of service, except where specifically stated otherwise in this booklet.
- If your enrollment in Part A and/or B of Medicare ends, this plan will continue to pay only the benefits listed below. This plan will not start paying the portion of Medicare-eligible expenses normally paid by Medicare. Benefits will only be provided for services and supplies which would have been Medicare-eligible had you been enrolled in Medicare Parts A and B. It is your responsibility to cancel your coverage if it no longer meets your needs in this event.

Benefits For Expenses Covered By Medicare

This Medicare supplement plan will cover the following:

- **Medicare Part A Deductible** This plan covers all of the Medicare Part A inpatient hospital deductible amount per Medicare benefit period.
- **Inpatient Hospital Coinsurance - Medicare Part A** Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period

> A **Medicare benefit period** starts on the first day of your inpatient hospital stay after your Part A hospital coverage begins. The period ends after you have been out of the hospital or other facility primarily providing skilled nursing or rehabilitative care for 60 days in a row (counting the day of discharge).

- **Lifetime Inpatient Reserve Days - Medicare Part A** This plan covers Part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
- **Hospice and Respite Care – Medicare Part A** This plan covers cost-sharing for all Part A Medicare-eligible hospice care and respite care expenses.

- **Skilled Nursing Facility Care –Medicare Part A** This plan covers the actual billed charges, up to the coinsurance amount, from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- **Blood Benefit - Medicare Parts A And B** This plan covers the reasonable cost of the first 3 pints of blood (or equivalent quantities of packaged red blood cells, as defined under federal regulations) required under Medicare Parts A and B, unless replaced in accordance with federal regulations.
- **Medicare Part B Deductible** This plan covers all of the Medicare Part B deductible amount per calendar year, regardless of hospital confinement.
- **Medicare Part B Coinsurance** After the Medicare Part B deductible is met in each calendar year, this plan covers the coinsurance amount of Medicare-eligible expenses under Part B (or the copayment amount, for hospital outpatient services paid under a prospective payment system), regardless of hospital confinement.

Benefits For Expenses Not Covered By Medicare

- **Extended Inpatient Service Benefit - Medicare Part A** Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.
- **One Hundred Percent Of The Medicare Part B Excess Charges** Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- **Medically Necessary Emergency Care In A Foreign Country** Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, when all of the following is true:
  - The care would have been covered by Medicare if provided in the United States
  - The care began during the first 60 consecutive days of each trip outside the United States

  This benefit is subject to a separate calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

WHAT THIS PLAN DOES NOT COVER

This plan will not provide benefits for:

- Charges in excess of the Medicare-approved charge (see **Definitions**), except for Part B excess charges as stated in **Benefits For Expenses Not Covered By Medicare** above

- Circumstances in which this plan’s payment would duplicate Medicare's payment
- Services or supplies which are required as a result of war or an act of war
- Services and supplies which are not specifically stated as covered under **Benefits For Expenses Covered By Medicare** and **Benefits For Expenses Not Covered By Medicare** above
- Amounts that exceed the provider’s billed charge
- Services and supplies which are excluded by Medicare, except as specifically stated under **Benefits For Expenses Not Covered By Medicare** above
- Services or supplies which are received when this plan is not in effect, or when you are not covered under this plan, except as stated in **Extended Benefits For Total Disability** below.
- Expenses for which claims are not filed within the time limits in **Claim Filing Deadlines** below.

ELIGIBILITY

To be covered under this plan, you must meet all the following requirements:

- You must be 65 or older **and** covered by both Medicare Part A and Medicare Part B.
- You must not have coverage under another Medicare supplement plan or under a Medicare Advantage plan (either a group plan or an individual plan) unless you are planning to replace that coverage with this plan.
- You must meet the Group's eligibility and enrollment requirements for coverage. (The Group should inform prospective subscribers of its eligibility and enrollment requirements.)

If the Group's contract includes dependent coverage, a person who is eligible as a dependent is treated as a subscriber under this plan except when specifically stated otherwise.

Please note that there are different eligibility and enrollment requirements for state residents and people who are enrolling in this Medicare Supplement plan through the Public Employees Benefits Board (PEBB) Program. The PEBB Program determines eligibility for an applicant applying for coverage through the PEBB Program. Premera Blue Cross determines eligibility for an applicant applying for coverage as a state resident. The benefits available under this Medicare Supplement plan described in this certificate of coverage are the same whether you enroll through the PEBB Program or enroll as a state resident, however, other provisions in this certificate may not apply or may be different for those that enroll through the PEBB Program as PEBB Program rules will apply.

LATE AND OPEN ENROLLMENT

If an eligible person fails to enroll for coverage under this plan when first eligible, the person may enroll only as described below.

Open Enrollment

The Group has the option of setting an open enrollment period for eligible people who did not enroll when first eligible. Not all groups allow open enrollment periods. Open enrollment rights may also differ between classes of eligible people.

Dependents must enroll on the same plan as the subscriber unless otherwise required by law or allowed by the Group's eligibility and enrollment rules.

Late Enrollment When Allowed By Law

People who are otherwise eligible for this plan may also apply when they lose coverage as described below. When they apply, they must give us proof that they had and lost the coverage as described below.

Eligible people may apply if:

- They lost retiree coverage through a group health plan sponsored by one or more employers or employee organizations.
- They left this plan to try a Medicare Advantage plan, Program of All-Inclusive Care for the Elderly (PACE), or Medicare cost, risk, or Select plan for the first time. They may apply if they tried one plan, more than one plan of the same type, or more than one type of plan. However, all four statements below must be true:
  - They were covered under each plan for less than 12 months.
  - Each plan (other than the most recent) must have been terminated involuntarily.
  - They switched plans within 63 days of the date the prior plan terminated, with no other coverage in between.
  - The effective date of the last plan was less than 2 years after the effective date of the first plan.
- At age 65 and upon first becoming eligible for Medicare Part A, they enrolled in one or more Medicare Advantage or PACE plans. All four statements above must also be true.
- They lost coverage under a Medicare Advantage plan, Medicare cost or risk plan, federal health care prepayment plan, PACE plan, or Medicare Select plan due to:
  - A permanent move outside the plan's service area
  - The termination of the plan for all enrollees or for enrollees in the applicant's area
  - The bankruptcy or a material breach of the contract by the issuer
  - The material misrepresentation by the issuer, producer or other entity acting on the issuer's behalf when the applicant was offered the coverage.
- They lost coverage under a Medicare supplement coverage due to:
  - The bankruptcy or material breach of the issuer
  - The material misrepresentation by the issuer, producer or other entity acting on the issuer's behalf when the applicant was offered the coverage.
  - Other involuntary termination of coverage

Enrollment Time Limit Eligible people must apply no later than 63 days after the date their prior coverage ended. However, if the prior plan was retiree group coverage, the 63-day period will start on the date the applicant received a notice that the retiree plan would be terminated. Applicants who received no notice must apply no later than 63 days after the date they found out that a claim was denied because the retiree group coverage had been canceled.

WHEN COVERAGE STARTS

Coverage will start on the effective date agreed upon by us and the Group for enrollment when newly eligible or during an open enrollment period or for late enrollment, whichever applies to you.

SUSPENSION DURING MEDICAID COVERAGE

Your coverage under this plan can be suspended at your request if you become entitled to medical assistance under Medicaid.

> This plan cannot be suspended due to your **Medicaid** assistance for more than 24 months.

Within 90 days of the date you become entitled to Medicaid, send us evidence of your Medicaid entitlement, along with your request to suspend this plan. Upon receipt, we will suspend subscription charges and return the balance of any subscription charges collected after your Medicaid entitlement, after we subtract paid claims. We will suspend benefits under this plan until you notify us in writing to put your coverage back in force.

When you lose entitlement to Medicaid, your request to reinstitute coverage under this plan must be received by us within 90 days of the date Medicaid entitlement ends. Upon receipt, your coverage will restart on the first day on which Medicaid is no longer available. You must also pay subscription charges starting on the date your coverage is once more in force. Your subscription charges will be determined on terms at least as favorable to you as the terms that would have applied had your coverage not been suspended.

WHEN COVERAGE ENDS

Cancellation By You You can cancel your coverage by giving at least 30 days' written notice or by not paying your subscription charges. You are responsible to cancel your coverage if you get other Medicare supplement coverage or Medicare Advantage coverage after this plan takes effect. You are also responsible to cancel if you lose coverage under Medicare Part A or B.

In the event of your death, all unearned subscription charges will be refunded to your estate. We reserve the right to ask for proof of the date of death.

Cancellation By The Group The Group has the right to cancel your coverage when you no longer meet the Group's eligibility requirements for coverage under this plan.

Cancellation By Premera We can only cancel your coverage under this plan when one of the following is true:

- Subscription charges are not paid within the Grace Period required under the contract, which will be no less than 10 days. In this case, your coverage will end on the last day for which subscription charges were paid.
- The contract for this plan is canceled as described below.
- There is material misrepresentation on your application. In this case, we may cancel this contract retroactively to its effective date. Should this occur, subscription charges paid for the ineligible period will be refunded, subject to our recovery of benefit payments made on your behalf.

  After your coverage under this plan has been in force two years from your effective date, no statement you made on your application shall be used to void your coverage under this plan.

IMPORTANT NOTE: If you are no longer eligible for coverage under this plan or the Group cancels the contract for this plan, you have a right to continued Medicare supplement coverage as stated under Conversion Right below.

Contract Cancellation

The contract for this plan will be canceled automatically if subscription charges aren't paid by the Group by the end of the Grace Period. Coverage will end on the last day for which payment was made. The contract may also be canceled as explained below.

- The Group may cancel the contract at any time by giving us 30 days advance written notice.
- We may cancel the contract upon 30 days advance written notice to the Group if the Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage

CONVERSION RIGHT

If this contract is canceled, you have the following rights:

- If the Group replaces this plan with another Medicare supplement plan through either Premera or another issuer, you have the right to continued coverage under the new plan. The new plan's benefits may not be the same as this plan's benefits.
- If the Group doesn't replace this plan with another Medicare supplement plan, you have the right to convert to a Premera individual Medicare supplement plan. You can choose to convert your coverage to:
    - A Premera individual Medicare supplement plan that has benefits that are equivalent to those of this plan, when such a plan is available; or
    - Any of Premera's available individual Medicare supplement plans.

If your coverage under this plan ends because you no longer meet the Group's eligibility requirements, you have the right to:

- Convert to a Premera individual Medicare supplement plan as stated above in this **Conversion Right** section; or
- Continue coverage under this plan, at the option of the Group. If the Group later cancels the contract for this plan, you will then have the right to convert to an individual Medicare supplement plan as stated above in this **Conversion Right** section.

Please note: You don't have answer medical questions or provide other proof of good health to convert your coverage as stated in this **Conversion Right** section. Your coverage under this plan will be credited toward the pre-existing condition waiting period of the individual Medicare supplement plan.

To convert your coverage to an individual Medicare supplement plan, you must apply within 31 days of the date coverage under this plan ended or the date you were notified that coverage was to end, whichever is later. You may be required to pay all of the subscription charges for continued Medicare supplement coverage.

EXTENDED BENEFITS FOR TOTAL DISABILITY

If you are "totally disabled" when your coverage ends for any reason other than material misrepresentation on your application, benefits can be continued as described below. "Totally disabled" means you are prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health, solely because of an injury or illness or disease.

Three things must be true for benefits to continue:

- The reason for your total disability was an illness, injury, or physical disability that occurred while this coverage was in effect.
- On the date coverage would otherwise end, you are incurring a "continuous loss." "Continuous loss" means you are continuously confined in a medical facility and admission occurred while your coverage was in force; or you are under a written plan of treatment prescribed by a physician which commenced while your coverage was in force, and you are receiving covered services in said plan one or more times per week. Your receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

When the above three things are true, contract benefits will remain available solely for the above continuous loss and only until the **first** of the following occurs:

- You are no longer confined in an inpatient facility.
- You are no longer totally disabled.
- You cease to experience the continuous loss.
- The maximum benefits of this plan have been provided.
- Six months of extended benefits have been provided.
- You become covered for the disabling condition under another Medicare supplement plan.

Within 90 days after coverage under this plan ends, you must certify your total disability and continuous loss in writing by providing us with a statement of disability and a plan of treatment from your physician. Furthermore, we reserve the right to require you or your physician to provide any medical records or documents which are necessary to verify your total disability and continuous loss.

YOUR CLAIMS FOR BENEFITS

How To File A Claim

Before your claims are filed with us, they should first be filed with and processed by Medicare.

In most cases, federal law requires your provider of care to file your claim for you. However, in the event you must file the claim yourself, here are the items you must send us:

- A copy of your Medicare Summary Notice;
- A completed claim form obtained from us or a copy of the itemized bill. The bill must contain at least the following information:
  - Your name
  - Your subscriber identification number
  - Name, address, and I.R.S. tax identification number of the provider
  - Date of onset of the illness or injury
  - Diagnosis or ICD code
  - Procedure code (CPT, ADA, or HCPCS)
  - Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an accidental injury, you must also send us the date, time, location, and brief description of the accident.

Claim Filing Deadlines

As soon as Medicare has processed your claim, please submit it to us in the manner stated above. We must receive your claim:

- Within 365 days of the date of hospital or skilled nursing facility discharge for inpatient expenses, or within 365 days of the date on which noninpatient expenses were incurred; or
- Within 90 days of the date you receive the Medicare Summary Notice.

The plan will not provide benefits for claims we receive after the later of these two dates. The plan will also not provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline.

Claims Payment

Payment for benefits provided under this plan for covered services or supplies will be made, **as prescribed by law**, to you, the provider of services or supplies, or jointly to you and the health care provider. Providers who are participating with Medicare will be paid directly. Payment of benefits in this manner, in good faith, shall discharge our obligation to the extent of the payment amount, so that we will not be liable to anyone aggrieved by the selection of payee.

We make every effort to process your claims as quickly as possible. We will tell you if this plan won't cover all or part of the claim no later than 30 days after we first receive the claim. 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 will let you know before the 30-day time limit ends if we need more time. If we need more information from you or your health care provider in order to decide your claim, we'll ask for it in our notice and allow you or your health care 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 will include:

- The reasons for the denial and a reference to the provisions of this plan on which it was 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 tell us in writing and give us the name, address and phone number where your appointee can be reached.

If You Have A Complaint

A **complaint** is an statement of discontent about a benefit or coverage decision or our customer service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but don't require, that you take advantage of this process when you're not content with a benefit or

coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, a representative will tell you.

When you have a complaint, call or write our Customer Service department. We'll let you know when we've received your complaint. We may also ask for more information when needed. When we receive all needed information, we'll review your complaint and respond as soon as possible, but never more than 30 calendar days.

How To Appeal A Claims Decision

An **appeal** is an oral or written request to reconsider 1) a decision on a complaint, or 2) a decision to deny, modify, reduce, or end payment or coverage. This includes admissions to and continued stays in a hospital or other facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you're appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

Although we'll accept an appeal made by phone to our Customer Service department, it's a better idea to put appeals in writing so you can keep copies for your records. Please send all written appeals to the address shown on the back cover of this booklet. We will let you know when we receive your appeal.

You have the right to give us comments, documents or other information to support your appeal. You can also ask to review documents relevant to your claim.

Appeals Process

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

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

Level I The Level I Appeal panel will give you its decision within 30 calendar days. This panel will include health care providers as needed. Persons involved in the initial decision will not be on the panel.

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

Level II Your appeal will be reviewed by a panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. The panel will give you a decision within 30 calendar days of the date we receive your Level II request.

Right Of Recovery

We have the right, upon demand, to recover payments for which the plan was not liable that were made to any of the following:

- Any insurance company

- Any other organization
- You or on your behalf
- Someone who is not eligible to receive benefits

Refunds of such payments or overpayments will be requested from the party to whom the payments were made. If reimbursement is not made, and such payment or overpayment was sent to you, recovery may be made through deductions from future benefits. However, recovery in this manner will only be made when the payment for such future benefits could have legally been made directly to you.

It is not the intent of the plan that you recover (from all sources) more than the total incurred medical expenses.

Third Party Liability

We have the right to be reimbursed for the amount of benefits we provided because of a condition or injury for which you are not legally liable. As explained below, reimbursement may be sought by you or by us from the party who is legally liable or from that party's insurance carrier.

You must notify us of any action or claim for a condition or injury for which we paid benefits. This includes promptly notifying us in writing of all of the following matters:

- The facts of your condition or injury;
- Any changes in your condition or injury;
- The name of any person responsible for your condition or injury, and that person's insurance carrier; and
- Advance notice of any settlement you intend to make of your action or claims.

If you bring an action or claim against another person, you must also seek recovery of the benefits we paid under this contract. We may, however, assert our right to recover benefits directly from the other person, or from you. If we do so, you do not need to take any action on our behalf. You must, however, do nothing to impair our right of recovery. Should we assert our right of recovery directly, we have the right to join as a party in the action or claim you brought.

In recovering benefits we have provided, we may either hire our own attorneys, or be represented by your attorney. If we choose to be represented by your attorney, we will pay, on a contingent basis, a reasonable portion of the attorney's fees which are necessary and which benefit our rights of recovery in the case. Usually, this portion will not be more than 20 percent of the amount we seek to recover. We will not pay for any legal costs incurred by you as the subscriber, or for costs incurred on your behalf.

You are only obligated to reimburse us in the amount that is left after you have been fully compensated.

Any person who is obligated to pay for the services or supplies for which benefits have been paid by us must pay to us the amounts to which we are entitled.

OTHER INFORMATION ABOUT YOUR PLAN

Availability Of Health Care

The services provided under this plan are, at all times, subject to availability of hospital facilities and the ability of hospitals, hospital employees, physicians, and other providers to furnish services. We assume no liability for conditions beyond our control which make it impossible for services provided by this plan to be obtained. Examples of these conditions are epidemics, natural disasters, civil disorder, war, and labor disputes.

Changes To The Contract

No agent is authorized to make any changes, additions, or deletions to the contract for this plan. Changes can be made only by an endorsement or revised certificate, when allowed by law, that is issued over the signature of a Premera officer.

We reserve the right to change subscription charges as stated in this booklet.

Compliance With Law

The contract for this plan is issued and delivered in the State of Washington and is governed by the laws of the State of Washington, except to the extent preempted by federal law. In the event any provision of the contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations:

- The validity of the rest of the contract shall not be affected.
- When such conflict is discovered, the contract will be administered to conform with the requirements of such laws and regulations as of their effective date.

Premera will comply with federal and Washington State nondiscrimination laws and regulations both in its employment practices and its administration of subscriber eligibility and benefits under this plan.

The Group And You

Your Group is your representative for all purposes under this plan and not the representative of Premera. Any action taken by the Group will be binding on you.

Limitation Of Liability

We are not responsible for the quality of care you receive from any institution or individual. The contract does not give you any claim, right, or cause of action against us based on an act or omission of any institution or individual.

Notice

Any notice that we are required to submit to the Group or to you will be considered delivered if mailed to the Group or to you 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 if mailed to Premera at the mailing address shown on the back cover of this booklet.

Notice Of Information Use And Disclosure

We may collect, use, or disclose certain information about you. This "protected personal information" (PPI) may include health information, or personal data such as your address,

telephone number or Social Security Number. We may receive this information from, or release it to, health care providers, insurance companies, or other sources.

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

- Underwriting and determining your eligibility for benefits and paying claims;
- Conducting care management, case management, or quality reviews; and
- Fulfilling other legal obligations that are specified in this contract.

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

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it. If a disclosure of PPI is not related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization. You also have the right to request inspection and/or amendment of records retained by us that contain your PPI. Please contact Customer Service and ask that a request form be mailed to you.

Uniformity

This coverage is intended to apply uniformly to all subscribers without discrimination.

Venue

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

- Within 3 years of the date we denied, in writing, the rights claimed under this plan; and
- In the State of Washington or the state in which you reside.

All suits or legal proceedings brought by us against you shall be filed within the appropriate statutory period of limitation. In all suits or legal proceedings brought by us, venue may lie, at our option, in King County, State of Washington.

Your Cooperation

You are under a duty to cooperate in a timely and appropriate manner with us in our administration of benefits or in the event of a lawsuit.

DEFINITIONS

Continuous Loss This term is used and defined in **Extended Benefits For Total Disability** section of this booklet.

Endorsement A separate attachment to this booklet or another part of the contract that specifies changes in the provisions or benefits.

Medically Necessary/Medical Necessity For any service or supply which is excluded by Medicare, but which is listed as covered under this plan, Premera will determine medical necessity in accordance with the following definition:

Medically necessary/medical necessity means 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.

Medicare The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare-approved Charge The dollar amount Medicare determines is reasonable for any Medicare-eligible service or supply.

Medicare-eligible Service, Supply, or Expense Any service, supply, or expense of the kind covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Benefit Period A period that starts on the first day you receive inpatient hospital care after your Part A hospital coverage begins, and ends after you have been out of the hospital or other facility primarily providing skilled nursing or rehabilitative services for 60 days in a row (including the day of discharge).

Subscriber The individual who has met the eligibility requirements of this plan and in whose name the coverage is established. A person enrolled as the result of a dependent relationship to a subscriber has the rights of a subscriber and is treated as a subscriber under this plan except when specifically stated otherwise.

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

Totally Disabled This term is used and defined in Extended Benefits For Total Disability section of this booklet.

We, Us and **Our** Premera Blue Cross (Premera).

You and Your The subscriber.

Where To Send Claims

MAIL YOUR CLAIMS TO

Premera Blue Cross
P.O. Box 91080
Seattle, WA 98111-9180

Customer Service

Mailing Address
Premera Blue Cross
P.O. Box 327
Seattle, WA 98111-0327

Physical Address
7001 220th St. S.W. Mountlake
Terrace, WA 98043-2124

Phone Numbers
Local and toll-free number:
1-800-817-3049

TTY number
for the hearing impaired:
711

When You Have An Appeal

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

Visit Our Web Site

www.premera.com

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association