The Board of Trustees of Whitman College

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SECTION I - MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS

INTRODUCTION

■ Notices

<u>Women's Health and Cancer Rights Act</u>

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician 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; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

<u>Statement of Rights Under the Newborns' and Mothers' Health Protection Act</u>

Under the federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

<u>Continuity of Coverage Provision for Employees in California</u>

The benefits which are described in this provision:

- Will be subject to all other parts of this Plan except as specifically stated in this Provision.
- Are for the purpose of compliance with the law of the state of California.

Exceptions to the Definition of Late Applicant - Special Enrollee

For medical and prescription drug benefits under this Plan, a person (you or your Dependent) will ***not*** be considered a late applicant and you may apply for coverage for such person under this Plan if:

- You:
  - Did not apply for coverage for the person within 31 days of the date you became eligible to do so because the person was covered under another health insurance plan or arrangement (other plan); and
  - Certified in writing, when you were first eligible, that you declined coverage under this Plan because of coverage under the other plan; and
  - Lost coverage under the other plan as a result of:
    - Exhausting the maximum period of COBRA coverage; or
    - Loss of eligibility for the other plan's coverage due to legal separation, divorce or death of a spouse; or
    - Termination of employment or reduction in the number of hours of employment; or
    - Termination of the employer's contribution for the other plan's coverage;

  and

INTRODUCTION - Continued

- Request coverage under this Plan within 31 days of the date coverage is lost under the other plan.

- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.

  Coverage will start on the date specified in the court order.

- You did not apply for coverage for the person within 31 days of the date you became eligible to do so because the person was covered under California's Medi-Cal "No Share of Cost" (MCNSC) coverage.

  You must have stated in writing that the MCNSC coverage was the reason you declined coverage under this Plan.

- You did not apply for coverage for the person within 31 days of the date you became eligible to do so and:
  - At the time you declined coverage you acknowledged in writing that the Employer notified you that the person would be considered a late applicant; and
  - The Employer is unable to produce the written statement.

  Coverage will start on the date on which you apply.

- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- You acquire a new Dependent, coverage will start:
  - In the case of marriage, on the date of marriage.
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

Pre-Existing Conditions

A pre-existing condition is an Illness or any related condition for which you or a Dependent received services, supplies or medication during the 3 months before coverage for you or your Dependent became effective under this medical Plan.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received after you or your Dependent has been covered under this Plan for 6 months.

Late Applicants

If you are a late applicant as described in this Plan, then benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 6 months after your enrollment date.

Portability of Coverage

A person (you or your Dependent) will receive credit toward satisfaction of the Pre-Existing Condition Limitation for the time he was covered under another health plan, but only if:

- your Service begins after the effective date of this Plan; and
- the person was covered under another health plan that meets the definition of "Creditable Coverage" within the 180-day period just before his enrollment date under this Plan and such coverage terminated within the 180-day period due to termination of employment or termination of the employer's contribution for coverage.

  Any eligibility waiting period that the person is required to satisfy under this Plan will not be taken into consideration in determining the 180-day period.

If the person was covered for a period of time under Creditable Coverage that is:

- greater than or equal to the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- less than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitations under this Plan to be reduced or waived.

■ About This Plan

Great-West Life & Annuity Insurance Company (Great-West) processes the benefits for this Plan under the name of **Great-West Healthcare**.

The Board of Trustees of Whitman College (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of January 1, 2008, the medical, prescription drug, dental and vision benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the medical, prescription drug, dental and vision benefit terms described in this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

The medical, prescription drug, dental and vision benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Great-West processes claims and provides other services to the Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

Defined terms are capitalized and have specific meaning with respect to medical, prescription drug, dental and vision benefits, see GLOSSARY.

Discretionary Authority

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Employer's self-funded medical, prescription drug, dental and vision benefit Plan. The Plan Administrator in his or her discretionary authority, will determine benefit eligibility under such self-funded Plan, construe the terms of the self-funded Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the self-funded Plan, including but not limited to eligibility for participation and claims for benefits.

For initial claim determination, the Plan Administrator has the discretionary authority to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Great-West Life & Annuity Insurance Company, 8505 E. Orchard Road, Greenwood Village, CO 80111 as the appeals fiduciary. Great-West will have the discretionary authority to determine whether a claim should be paid or denied on appeal and according to the Plan provisions.

Plan Modification/Termination

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

PPO MEDICAL BENEFITS SUMMARY

This summary provides a general description of your medical benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Copay Amount for Network Services

Office Visits	$20.00
Office visits for Outpatient Mental Health Conditions - Network	$20.00
Office visits for Naturopathy - Network	$20.00

Deductible

The calendar year deductible applies to all covered expenses except:

- expenses payable at 100%. Note: Expenses payable at 100% because the Breakpoint has been reached will be subject to the deductible.

- expenses subject to a copay

- expenses for Acupuncture and Spinal adjustment treatment

- expenses for Diagnostic X-rays and lab tests as part of an office visit or at an Independent Lab

Individual Calendar Year Deductible	$250.00
Family Calendar Year Deductible	$500.00

Medical Management Program

Non-compliance Penalty	50% reduction per claim

Percentage Payable after any applicable Deductible or Copay

Pre-admission Testing	100%
Facility charges by a licensed birthing center	100%
Home Health Care	100%
Skilled Nursing Facility	100%
Outpatient Surgery, including surgery performed in a Doctor's Office	100%
Hospice Care	100%
Hospital	
- Network	90%
- Services outside the PPO Network Area	80%
- Non-network	70%
Physician charges for Hospital care and inpatient Surgery	
- Network	90%
- Services outside the PPO Network Area	80%
- Non-network	70%
X-rays and Lab Tests	
- ordered as part of Emergency Room Care in a	
* Network Hospital	90%
* Hospital outside the PPO Network Area	80%
* Non-network Hospital	90%

PPO MEDICAL BENEFITS SUMMARY - Continued

- ordered as part of Hospital care in a	
* Network Hospital	90%
* Hospital outside the PPO Network Area	80%
* Non-network Hospital	70%
- ordered as part of an Office Visit (including Preventive Care Office Visits) and performed in a	
* Network provider's office or Network x-ray or lab facility	90%
* Provider outside the PPO Network Area	80%
* Non-network provider's office or Non-network x-ray or lab facility	90%
Durable Medical Equipment	80%
Office Visits	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Chemical Dependency Treatment	100%
Outpatient Mental Health Conditions Treatment	
- Network (after $20.00 copay)	100%
- Non-network	70%
Naturopathy	
- Network (after $20.00 copay)	100%
- Non-network	70%
Emergency Room Care	
- Network	80%
- Services outside the PPO Network Area	80%
- Non-network	80%
Acupuncture and Spinal Adjustment Treatment	
- Network	80%
- Services outside the PPO Network Area	80%
- Non-network	80%
Transplant Expenses	
- Travel Expenses to and from a Great-West Healthcare Transplant Network facility	100%
- Other Transplant Expenses	
* Great-West Healthcare Transplant Network facility	90%
* Other Network facilities	Not Covered
* Services outside the PPO Network Area	Not Covered
* Non-network	Not Covered
Other Covered Expenses including second surgical opinions	80%
Individual Breakpoint	$15,000.00
Family Breakpoint	$30,000.00

Calendar Year Benefit Maximum

Home Health Care	1 visit per day up to 100 visits

PPO MEDICAL BENEFITS SUMMARY - Continued

Home Health Respite Care	5 days
Skilled Nursing Facility	90 days
Inpatient Treatment of Mental Health Conditions	20 days
Outpatient Treatment of Mental Health Conditions	20 visits
Spinal Adjustment Treatment	30 visits

Maximum Benefits for Treatment of Chemical Dependency

In Any 24 Month Period	$14,000.00

Lifetime Benefit Maximum

Inpatient Treatment of Mental Health Conditions	50 days
Transplant Travel Expenses to and from a Great-West Healthcare Transplant Network facility. Certain travel expenses are limited to a daily maximum. See the "Transplants" benefit provision for more details.	$10,000.00

Maximum Benefit for all Covered Expenses

Lifetime benefit per Member	$2,000,000.00

PRESCRIPTION DRUG BENEFITS SUMMARY

This summary provides a general description of your prescription drug benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Retail Network Pharmacy - *up to a 30-day supply*

Tier 1 - Generic Drug copay	100% after $10.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after $20.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after $40.00 copay

Non-network Pharmacy - *up to a 30-day supply*

Member must pay 100% of drug cost at time of purchase and submit a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost after the copay.

Ninety-day Retail Network Pharmacy Program - *80 to 90-day supply*

Tier 1 - Generic Drug copay	100% after $30.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after $60.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after $120.00 copay

Mail Order Drug Program - *up to a 90-day supply*

Tier 1 - Generic Drug copay	100% after $20.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after $40.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after $80.00 copay

Specialty Pharmacy Program - *for certain high-cost drugs*

The copay for Specialty drugs will mirror either the Retail Network Pharmacy or Mail Order Drug Program copays. The way the prescription is written by the physician ***(i.e., 30-day supply or 90-day supply)*** will dictate the copay. A 30-day supply will require a Retail Network Pharmacy copay. A 90-day supply will require a Mail Order Drug Program copay.

DENTAL BENEFITS SUMMARY

This summary provides a general description of your dental benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Deductible

The Calendar Year deductible applies to all covered expenses except for Preventive Care.

Individual	$50.00
Family	$100.00

Percentage Payable after any Deductible

Preventive Care	100%
Basic Care	80%
Major Care	50%

Calendar Year Benefit Maximum

Preventive, Basic and Major Care	$1,500.00

VISION BENEFITS SUMMARY

This summary provides a general description of your vision benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Calendar Year Deductible	None
Percentage Payable	
Eye examinations, eyeglass lenses and frames or contact lenses	100%
Benefit Maximum (per Calendar Year)	
Eye examinations	1 exam covered with a $20.00 co pay
Eyeglass lenses and frames or contact lenses	$150.00

ELIGIBILITY

■ Eligible Employees

For the purpose of medical, prescription drug, dental and vision benefits, an eligible Employee is a person who is in the Service of the Employer and is a resident of the United States.

Retired Employee

An Employee who is currently covered for Retiree benefits and;

- has been retired from active Service with the Employer; and
- has attained at least age 60 on the date he retires; and
- just prior to the date of his retirement had been covered for medical benefits:
  - for at least 10 years; or
  - for at least 5 years and submits in advance to the Employer for the entire cost of the coverage

Retired Employees are eligible for medical, prescription drug, dental and vision benefits.

Service

Work with the Employer on an active, full-time and full pay basis for at least:

- 1350 hours each year to qualify for Dentalcare Benefits; and
- 910 hours each year to qualify for Medical, Vision and Prescription Drug Benefits.

For Retired Employees, "Service" means the period during which you are retired according to the definition of "Retired Employee".

■ Eligible Dependents

It is your responsibility to notify the Employer when a covered Dependent is no longer eligible for coverage.

Your Dependents must live in the United States to be eligible for coverage.

A spouse, domestic partner or child who is covered under this Plan as an Employee may not be covered as a Dependent.

Eligible Dependents are:

- your legal spouse or, as defined below, your Domestic Partner.
- an unmarried child, as defined below.

Domestic Partner

"Domestic Partner" means the person, regardless of gender, named in the Affidavit of Domestic Partnership that you have submitted to and has been approved by the Employer.

Child

"Child" means:

- your natural child.
- your stepchild.
- a natural child of your covered minor Dependent.
- your adopted child. This includes a child placed with you for adoption.

  "Placed for adoption" means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child's placement is considered terminated upon the termination of such legal obligation.
- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- a foster child.

- a child of your covered domestic partner.

The child must meet the age requirement described below and depend on you for financial support. The support requirement does not apply to a child who is recognized under a medical child support order as having a right to enrollment under the Plan.

Dependent Child Age Requirement

The child

- Any unmarried child up to the age of 25.

Coverage for an eligible dependent child will continue until the last day of the month that they turn age 25.

Handicapped/Disabled Child

The age limit does not apply to a child who becomes disabled, or became disabled, before reaching the age limit and who cannot hold a self-supporting job due to a permanent physical handicap or mental retardation.

"Physical handicap/mental retardation" means permanent physical or mental impairment that is a result of either a congenital or acquired Illness or Injury leading to the individual being incapable of independent living.

"Permanent physical or mental impairment" means:

- a physiological condition, skeletal or motor deficit; or
- mental retardation or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

At reasonable intervals, but not more often than annually, the Plan may require a Doctor's certificate as proof of the child's disability.

Medical Child Support Order

A medical child support order is a ***qualified*** medical child support order (QMCSO) or a ***qualified*** national medical support notice issued by a state court or administrative agency that requires the Plan to cover a child of an Employee, if the Employee is eligible for benefits under the Plan.

When the Employer receives a medical support order, the Employer will determine whether the order is "qualified".

If the order is determined to be qualified, and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing medical child support orders.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee, Retired Employee or Dependent in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the date you satisfy any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent (e.g. marriage, birth, adoption) if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent. If you have already elected Dependent coverage, any new Dependents will be covered automatically.

The 31-day application period is extended to a period of 60 days for:

- A newborn child. Coverage will start from the moment of birth; and
- An adoptive child. Coverage will start for:
  - An adoptive newborn, from the moment of birth if the child's date of placement is within 60 days after the birth; or
  - Any other adoptive child, from the date of placement.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

Medical, Prescription Drug, Dental and Vision Benefits

A late applicant may apply for coverage only during an open enrollment period. The Plan Administrator can tell you when the open enrollment period begins and ends. Coverage for a late applicant who applies during the open enrollment period will begin on the first day of the month following the close of the open enrollment period.

You may waive coverage for medical and prescription drug benefits only, or you may waive coverage for all benefits described in this section. Proof of Good Health is not required if you apply for coverage at a later date.

For medical, prescription drug, dental and vision benefits, a Member is ***not*** a late applicant if:

- You did not apply for coverage within 31 days of the eligible date because the Member was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
  - Exhausting the maximum period of COBRA coverage; or
  - Loss of eligibility for the other plan's coverage due to legal separation, divorce, cessation of dependent status, death of a spouse, termination of employment or reduction in the number of hours of employment; or
  - Loss of eligibility for the other plan's coverage because the Member no longer lives or resides in the service area; or
  - Loss of eligibility for the other plan's coverage because the Member incurs a claim that meets or exceeds the lifetime maximum for that plan; or
  - Termination of benefits for a class of individuals and the Member is included in that class; or
  - Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.

- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage for yourself, your spouse and any newly acquired Dependents.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the court ordered date.
- You acquire a new Dependent, coverage will start:
  - In the case of marriage, on the date of marriage.
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

■ What If I Was Covered for Health Benefits Under the Employer's Prior Plan?

A Member who had similar coverage for health benefits under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan effective date.

Any waiting period under this Plan will be reduced by the part of the waiting period that had been satisfied under the prior plan.

Any calendar year or lifetime maximum under this Plan will be reduced by the amount paid under Employer's prior plan that was in effect immediately prior to the transferring of claims processing to Great-West.

"Health benefits" mean medical, prescription drug, dental and vision benefits.

If a Member was on COBRA or any other continuation coverage or extension of benefits under the prior plan and that plan terminated, coverage will be provided for that Member until the earlier of:

- The date on which coverage would end under the terms of the Plan; or
- The last day of the period for which coverage would have been provided had the prior plan not terminated.

If a Member was covered under any extension of benefits under the prior plan, the benefits provided under this Plan will be the same as those provided by the prior plan, less any amount paid under the prior plan.

If you were on Family and Medical Leave on the effective date of this Plan and you were covered under the Employer's prior plan on the date of its termination, then you will become covered for the benefits provided under this Plan as of its effective date.

Medical Deductible and Breakpoint Credits

Any amount a Member has already paid toward the calendar year medical deductible under the prior medical plan will be applied to this Plan's calendar year medical deductible.

Any amount of covered expenses a Member has already used to satisfy any calendar year breakpoint under the prior medical plan will be applied to this Plan's calendar year breakpoint.

WHEN COVERAGE BEGINS & ENDS - Continued

Special Benefits For Pre-Existing Conditions

These benefits apply if a Member would not be eligible for coverage under the Plan because of the pre-existing conditions limitation and is not eligible for benefits under the prior plan because expenses were incurred after termination of that plan.

The amount of benefits will be the lesser of the amount that would have been paid under the prior plan if it had stayed in force and the amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time a Member has already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

If coverage transfers to this Plan within 90 days from the time your coverage terminated under a prior carrier and coverage under a prior carrier was "Qualifying prior coverage", then:

- A Member will be eligible to receive credit toward the pre-existing conditions limitation in this medical Plan, if he or she was covered under the prior plan for less than 3 months. The pre-existing conditions waiting period referred to in this provision will be reduced by the number of consecutive months the Member was covered under the prior plan.
- A Member will not be required to satisfy the pre-existing conditions limitation referred to in this medical Plan, if he or she was covered under the prior plan for longer than 3 months.

  The term "Qualifying prior coverage" will include:
  - A plan that is substantially similar to this Plan.
  - A self-funded plan, including a state or local government self-funded plan.
  - The Uniform Plan.
  - The Basic Health Plan.
  - The Washington State Health Insurance Pool.
  - Medicaid.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class on the date that the Member's class status changes.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.
- The date Loss of Residence occurs.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends; or
- The date Loss of Residence occurs; or
- The date your Dependent is no longer eligible for benefits; or
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

WHEN COVERAGE BEGINS & ENDS - Continued

A Certificate of Creditable Coverage (CCC) will be sent when coverage for a Member ends. In addition, a CCC may be requested from the Plan Administrator at any time while a Member is covered under the Plan and up to 24 months after coverage ends.

■ Can I Continue My Coverage If I Become Ineligible?

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

Continuation of Medical, Prescription Drug, Dental and Vision Benefits during an Illness, Approved Leave of Absence or Temporary Layoff

If your Service ends due to Illness, coverage will continue for 90 days after your Service ends.

If your Service ends due to approved leave of absence or temporary layoff, coverage will continue for 31 days after your Service terminates.

Your continuation coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

Continuance of Medical, Prescription Drug, Dental and Vision Coverage During a Labor Dispute

This provision applies when your Employer pays all or part of the cost of your medical, prescription drug, dental and vision coverage under the Plan. If there is a work stoppage by the Employees covered under the Plan as a result of a labor dispute, then, subject to payment of the cost of your coverage, the Plan will continue in force for the period of the stoppage but in no event for more than 6 months. If you elect to continue your coverage under this provision, then you must pay the cost of the coverage. This payment must be made to the union, unions or Employer. The cost of your coverage will be the rate applicable to your class on the date the work stoppage occurs.

Nothing in this provision will limit any right the Employer has under the terms of the Plan. This includes:

- the right to change the contribution rate as a result of experience rating; and
- the right to terminate the Plan.

During the period of work stoppage the benefits provided under the Plan cannot be changed or altered.

Your coverage will end automatically on the date on which you begin permanent work for pay, profit or gain with any employer.

Continuation of Dependent Medical, Prescription Drug Benefits After Your Death

Coverage is continued for ONE YEAR after your death. Contributions for this coverage are not required. This coverage will also be provided to a child conceived before but born after your death who would have been covered as your Dependent if your coverage had stayed in force. This coverage runs concurrent with COBRA coverage. Coverage being continued for your Dependents after your death will end sooner:

- for your surviving spouse, if he or she becomes entitled to Medicare.
- for your surviving child, if he or she no longer meets the definition of Dependent.
- for your surviving spouse or child if he or she becomes covered by another group plan.

Continuation of Coverage under Federal Laws and Regulations

If coverage would otherwise terminate under this Plan, you and your Dependents may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES, CONTINUATION OF COVERAGE - FMLA and CONTINUATION OF COVERAGE - COBRA.

■ Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, it will be reinstated on the date you return to work with the Employer. You must return within 3 month(s) to be reinstated.

On the date you return to work, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

Reinstatement When Coverage Ends Due to Loss of Residence

Coverage for a Member whose coverage ended due to Loss of Residence will be reinstated:

- for an Employee, on the day after completing 30 consecutive days of Work in the United States;
- for a Dependent, on the day after completing 30 consecutive days residence in the United States.

The Member must return to the United States within three months of the date the Loss of Residence occurred to be reinstated. Coverage will be on the same basis as that being provided for any other active Employee and his or her Dependents on the date coverage is reinstated. However, any restrictions on the coverage that were in effect before reinstatement will continue to apply.

PPO MEDICAL BENEFITS

■ How Does the Plan Work?

The PPO plan includes a nationwide network of Hospitals and Doctors and a Medical Management Program. For the names of network providers, contact Member Services at the phone number or access the on-line directory at the website address shown on the Member ID card.

Benefits received from network providers are payable at a higher level than benefits received from non-network providers. Members are responsible for confirming that a provider is a network provider.

If a Member is traveling and needs care for a non-Emergency Medical Condition, contact Member Services for help in locating a network provider. Since the PPO network is nationwide, the Member may be able to see a network provider and receive a higher level of benefits. If a Member is outside the PPO network area, benefits will be payable as shown in PPO MEDICAL BENEFITS SUMMARY.

Network providers will submit Members' claims and take care of getting Medical Management approval when necessary. When a non-network provider is used, the Member will need to file their own claim and make sure treatment is approved by Medical Management. See "Medical Management (MM) Program" for information about pretreatment authorization.

<u>Special Services</u>

Certain services are payable at the network level even when not performed by a network provider. These services include:

- Services (other than surgical assistance and Emergency Room Care) of a non-network provider such as, but not limited to: inpatient consultations, neonatology, x-rays and lab tests, radiology, anesthesiology and other specialists over whom the Member has no control in selecting after admission, when the Member is admitted for inpatient or outpatient care in:
  - a network facility, if the admission and the provider's services are approved by Medical Management.
  - a non-network facility, if the admission and the provider's services are approved by Medical Management, and the authorization indicates that the services are payable at the network level.
- Services of a non-network assistant surgeon, surgical assistant or any other non-network provider who is qualified to assist during surgery (other than surgery performed as part of Emergency Room Care), if the surgery is performed by a network Doctor in a network facility. The use of an assistant during surgery must be appropriate for the type of surgery rendered.
- Inpatient care provided in a non-network Hospital or by a non-network Doctor immediately following Emergency Room Care through stabilization if the services are approved by Medical Management.

<u>Supplemental Network</u>

Members who use a non-network provider may reduce their out-of-pocket expenses by choosing a provider participating in a supplemental network. This supplemental network is available to Members who choose a provider outside the primary network. Call Member Services for the names of providers who are participating in the program. Certain claims from non-network providers who are not in the supplemental network may, however, qualify for negotiation. Providers that participate in the supplemental network or agree to negotiate are considered non-network providers under the Plan. The Member is responsible for pretreatment authorization for all services and supplies that require pretreatment authorization.

<u>Transitional Care for Members upon Termination of a Provider from the Network</u>

If a Member's provider ceases to be a network provider for reasons other than quality-related reasons, fraud, or failure to adhere to Great-West's policies and procedures, coverage may continue for a specified period of time for treatment in progress for a Member who is:

- in her third trimester of pregnancy; or
- receiving care for end-stage renal disease and dialysis; or
- receiving outpatient mental health treatment; or
- terminally ill, with anticipated life expectancy of six months or less; or
- undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Member's health; or

- undergoing chemotherapy or radiation therapy for treatment of cancer; or
- a candidate for a solid organ or bone marrow transplant.

Contact Member Services to obtain a Transition of Care Request Form. The Transition of Care Request Form must be received by Great-West within 60 days of the provider's termination date. If your request is approved, care provided will be subject to the same copays, deductibles, coinsurance and limitations as care given by a network provider.

Medical Management (MM) Program

Medical Management will review and make an authorization determination for urgent, concurrent and prospective medical services, and prescription drugs for Members covered under the Plan. Medical Management will also review the medical necessity of services that have already been provided.

Medical Management will determine the medical necessity of the care, the appropriate location for the care to be provided, and if admitted to a Hospital, the appropriate length of stay.

If a pretreatment request does not follow the Medical Management procedures, the provider will be notified of the established procedures no later than 5 days after receipt of the request.

Your Doctor must call Medical Management (MM) for pretreatment authorization. If a Member uses a non-network Doctor, the Member must make sure that treatment is approved by Medical Management.

Network Doctors are responsible for contacting the MM Program for pretreatment authorization. If a non-network Doctor does not get pretreatment authorization or if a Member does not follow the recommended care plan, covered expenses will be reduced by a 50% non-compliance penalty. The non-compliance penalty cannot be applied toward the calendar year deductible or breakpoint.

Care received in an emergency room does not require pretreatment authorization. However, if hospitalization or surgery is required because of an emergency, the Member's Doctor must call MM within 48 hours after care is given.

Certain services and supplies require pretreatment authorization, including, but not limited to:

- Air ambulance, when used for non-Emergency Medical Conditions.
- Durable medical equipment charges over $500.
- Genetic testing.
- Home health care (including IV therapy).
- Hospital admissions, including partial hospitalization programs for mental health treatment.
- Outpatient high technology radiology (examples include: CAT scans, PET scans and MRIs).
- Outpatient surgery, except for surgery performed in a Doctor's office.
- Prescription drugs that need to be reviewed for Medical Necessity. This includes, but is not limited to:
  - certain drugs that are used for specialized medical treatment, to ensure that the drugs are used appropriately. Examples of medical conditions that may require specialized drugs include: arthritis, growth deficiencies and immune disorders; and
  - certain drugs that have multiple uses, to ensure that the drug is used according to acceptable medical practice and FDA guidelines.
- Renal dialysis.
- Skilled nursing facilities.
- Transplant evaluations.

For more information about services and supplies that require pretreatment authorization, contact Member Services at the phone number on the ID card.

Medical Management will review and render an authorization determination as described below.

- Urgent Care Requests

  For an urgent care request, MM will notify the Member and the provider of the authorization decision:

  - no later than 24 hours after receipt of a request involving concurrent care, if the request is made at least 24 hours prior to the expiration of the previously approved care; and
  - no later than 72 hours after receipt of any other urgent care request.

  If MM does not have all the information needed to process an urgent care request, MM will notify the Member or provider within 24 hours after receipt of the request and give details as to what additional information is required. The requested information should be provided within 48 hours or the authorization request may be denied. MM will notify the Member and provider of the authorization decision within 48 hours after the requested information has been received.

  MM will provide either verbal or written notice of the decision. When verbal notice is provided, a written notice will be sent within 3 days.

- Non-urgent Care Requests

  For a non-urgent care request, MM will notify the Member and provider of an authorization decision no later than 15 days after receipt of the request. If an authorization decision cannot be made within the 15-day period, an extension of up to 15 days may be requested. If additional information is needed, the Member or provider will be notified within the initial 15-day period and given details as to what information is required. The requested information should be provided within 45 days after receipt of the request or the authorization request may be denied.

  An authorization decision will be made no later than 15 days after MM receives the requested information, unless the Member or provider agrees to a voluntary extension of time.

  Medical Management will send the Member and the provider written notice of all authorization determinations.

If previously authorized benefits are reduced or terminated, MM will send notice of this decision ***prior*** to any reduction or termination of benefits.

If a Member receives notice of an adverse determination, in whole or in part, the Member or the Member's Authorized Representative can appeal the decision.

An "Authorized Representative" means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment and appeal requests. The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

"Adverse determination" means a determination of non-approval, in whole or in part, of a pretreatment or claim payment request.

If the MM decision is an adverse determination, the Member will be sent written notice that will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the request and why the information is needed, the appeal procedures and time limits, including procedures and time limits for urgent care appeals, and the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

The adverse determination notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge; and
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

Appeal of Medical Management Decision

Appeal of a Medical Management decision should be requested within 180 days after receipt of an adverse determination. You have the right to review and/or request copies of relevant documents, free of charge, and to submit written comments, documents and issues.

One level of appeal must be completed for appeals involving urgent care and two levels of appeal must be completed for all other appeals involving a MM adverse determination, before a Member may bring civil action under ERISA for an adverse determination. (See STATEMENT OF ERISA RIGHTS.) The appeal review will consider written comments, documents and any other information submitted by the Member, Authorized Representative or Doctor, regardless of whether the documentation was reviewed as part of the initial determination.

- **Level I Appeal**

  The first appeal level is an internal review by MM. Upon receipt of an initial appeal of a denied request for medical services, MM will assign the review to a board certified Physician Reviewer who is in the same or similar specialty that typically manages the service under review and ***who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination.***

  The Member and the provider or other Authorized Representative will be sent written notice of an appeal determination:

  - no later than 72 hours after receipt of an appeal involving urgent care; and
  - no later than 15 days after receipt of an appeal involving non-urgent care; and
  - no later than 30 days after receipt of an appeal involving services that have already been provided.

  If the appeal decision upholds an adverse determination, and you decide to appeal the decision, you may proceed to Level II. For appeals involving urgent care, Level II is voluntary.

- **Level II Appeal**

  If the first level internal review denies authorization, in whole or in part, a second level appeal review may be requested. The second level appeal is an external review by an independent review entity and is binding on the Plan. The written request for external review must be submitted to Medical Management within 60 days after receipt of the first level appeal determination. An external review will be provided at no cost to the Member.

  A Doctor or a group of Doctors in the same or similar specialty that typically manage the service under review and who is not affiliated with Medical Management will conduct the external review.

  The Member and the provider will be sent a written notice of the external review determination:

  - no later than 15 days after receipt of the second level appeal request for preauthorization of services; and
  - no later than 30 days after receipt of the second level appeal request for authorization of services that have already been provided.

  If the external review results in a denial of the requested service, the Member has the right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

Members will be sent written notice of an adverse determination upon completion of a Level I appeal and upon completion of a Level II appeal. The notice will include:

- the reason(s) for the determination;
- reference to the Plan provision(s) on which the determination is based;
- the Member's right to review and request copies of all relevant documents, free of charge;
- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge;

- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

The notice will also include the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

Appeal of an adverse determination involving urgent care may be submitted either orally or in writing and will be expedited.

Medical Outreach Program

The Medical Outreach Program includes various initiatives to assist Members to manage their health concerns and to stay healthy. The Medical Outreach Program includes:

- A Disease Management Program;
- A Care Management Program; and
- A Health Management Program.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card for more information about these Programs.

Disease Management Program

If this Plan participates in the Disease Management (DM) Program, Members have access to educational materials and individualized care plans designed to help a Member manage a chronic medical condition such as pain, asthma, diabetes, coronary disease and chronic lung disease. The DM Program also provides services and support for Members with conditions classified as Oncology, End Stage Renal Disease (ESRD) and Neonatology. The DM Program is staffed by specially trained nurses who are available 24 hours a day, 7 days a week.

Members who may benefit from the DM Program are identified through a variety of means, such as medical and/or pharmacy claims, health risk assessments, preauthorization, physician referrals and self referrals. Each enrolled Member will receive tailored educational material depending on the Member's condition. The care managers in the DM Program will assist in setting clinical goals and monitor adherence to goals. Based on the severity of the condition, the care managers will schedule ongoing telephonic contact or home care visits by trained professionals. The Member's Doctor will be able to access the information provided to Members.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card to confirm that this Plan participates in the DM Program and to access the DM Program.

There are no additional out-of-pocket expenses for these services obtained through the DM Program. If this Plan includes a Lifetime Maximum, then any costs associated with the Member's participation in the DM Program will be applied to the Maximum Benefit for All Covered Expenses.

Care Management Program

The Care Management (CM) Program manages the care of Members with serious Illnesses. Under the CM Program, if a Member requires inpatient care, such as surgery followed by long term medical care, a case manager who will work on behalf of the Member is assigned to the Member.

The case manager will help to coordinate and provide the most appropriate care in the most cost-effective manner. This includes handling the pretreatment authorization process, providing concurrent review for continued stay as an inpatient in a Hospital, discharge planning and post-discharge follow-up by the clinical staff to ensure that the Member is receiving proper care and support outside of a Hospital setting.

Members who may benefit from the CM Program are identified through a variety of means, such as the pretreatment authorization process and medical claims. Generally, Members may choose to participate in the CM Program.

If a Member chooses to participate in the CM Program and if a Member and the Member's Physician decide that the recommended alternative treatment plan is right for the Member, it will be covered on the same basis as the care and treatment for which it is substituted.

Members with certain serious Illnesses must participate in the CM Program.

A Member may call the toll-free Member Services telephone number or access the website shown on his or her ID card to find out more about participation in the CM Program.

Health Management Program

The Health Management (HM) Program offers online health and wellness services, programs and other resources that enable Members to more easily and effectively obtain information about health-related topics. This includes the latest medical advances and a variety of information about eating a healthy diet and exercise support and smoking cessation.

Calendar Year Deductible and Copay

A calendar year deductible is the amount of covered medical expenses that must be satisfied before the Plan begins to pay benefits.

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the deductible for that year will also be applied to the deductible for the next calendar year.

A copay is an amount a Member pays for care at the time of service.

Allowable Covered Expenses

All medical benefits are subject to allowable covered expense guidelines.

Network providers have agreed to a set fee schedule. Members are not responsible for expenses over the scheduled amount for covered services. Members are responsible for any applicable copays, deductibles and coinsurance.

For non-network providers, the allowable covered expense is determined by usual and customary charge guidelines. The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a provider and the fee usually charged by other providers in the same geographical area for these services and supplies. The Member must pay any amount over usual and customary charges.

■ What's Covered?

PPO MEDICAL BENEFITS SUMMARY shows the payment percentage, deductible and copay amounts applicable to various covered expenses. Any benefit maximums applied to specific covered expenses and calendar and lifetime benefit maximums for ***all*** covered expenses are also shown in PPO MEDICAL BENEFITS SUMMARY.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services. This amount is in addition to any deductible or copay amounts. You are also responsible for any amount over the allowable covered expense limit described in the Plan provision "Allowable Covered Expenses".

Services must be Medically Necessary as defined in the GLOSSARY. Unless otherwise noted for a particular service, services must be required as a result of symptoms of Illness. Expenses are covered only if incurred while the Member is covered for these medical benefits.

PPO MEDICAL BENEFITS - Continued

<u>Emergency Care</u>

Emergency Room Care

If you need care for an Emergency Medical Condition, go to the nearest medical facility. Coverage for an Emergency Medical Condition is available 7 days a week, 24 hours a day. This includes care received outside of the United States, required to stabilize the Member's condition for return to the United States. Pretreatment authorization is not required prior to receiving care in an emergency room.

X-rays and lab tests are not included as part of the Emergency Room Care coinsurance percentage shown in PPO MEDICAL BENEFITS SUMMARY, a separate coinsurance percentage applies to these services.

Inpatient Hospital Care immediately following Emergency Room Care

Inpatient care for an Emergency Medical Condition includes both Hospital and Doctor's charges for initial medical screening examination as well as Medically Necessary treatment which is immediately required to stabilize the Member's condition. After care is provided for an Emergency Medical Condition, Medical Management must be contacted within 48 hours.

When care is provided in a non-network Hospital or by a non-network Doctor, the inpatient services and supplies received in the Hospital and the Doctor's charges are paid at the network level through stabilization if the services are approved by Medical Management.

When care is provided in an out-of-area Hospital, the inpatient services and supplies received in the Hospital and the Doctor's charges will be covered at the Services Outside the PPO Network Area level shown in PPO MEDICAL BENEFITS SUMMARY.

After the Member's condition is stabilized, the Member or his/her Authorized Representative will be presented with the options described below. The inpatient Hospital and Doctor's charges incurred after the Member's condition is stabilized, are determined based on the ***network status of the provider***. If:

- the Member elects to be transferred to a network Hospital after stabilization in a non-network Hospital or in an out-of area Hospital, then the benefits will be paid at the network Hospital and Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY. Any transportation costs associated with this transfer will be paid at the network level.
- the Member elects to continue to stay in a non-network Hospital and:
  - receives treatment from a non-network Doctor after stabilization of the Emergency Medical Condition, then the benefits will be payable at the non-network Hospital and Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.
  - receives treatment from a network Doctor after stabilization of the Emergency Medical Condition, then the benefits will be payable at the non-network Hospital and network Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.
- the Member elects to continue to stay in an out-of area Hospital, then benefits will be payable at the Services Outside the PPO Network Area level shown in PPO MEDICAL BENEFITS SUMMARY.
- the Member is admitted to a network Hospital and is under the treatment of a non-network Doctor, and if:
  - the Member elects to transfer care to a network Doctor associated with the network Hospital, then the benefits will be payable at the network Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.
  - the Member elects to continue to receive care from a non-network Doctor associated with a network Hospital, then the benefits will be payable at the non-network Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

Hospital Care and Surgery

The Plan covers semi-private room and board and ICU expenses as well as other inpatient and outpatient services, supplies and Doctor's charges. Hospital and Doctor charges for infant care through the first seven days of life are covered if you have elected Dependent coverage.

X-rays and lab tests ordered as part of Hospital Care or as part of care received in an ambulatory surgical center are payable at the X-rays and Lab Tests coinsurance percentage shown in PPO MEDICAL BENEFITS SUMMARY.

Skilled Nursing Facility

The Plan covers semi-private care, including room and board, in a licensed skilled nursing facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and the Member must continue to show functional improvement.

Office Visits

The Plan covers most services and supplies in a Doctor's office, including the cost and fitting of FDA-approved contraceptive devices.

X-rays and lab tests ordered during an Office Visit are payable at the X-rays and Lab Tests payment percentage shown in PPO MEDICAL BENEFITS SUMMARY. The payment percentage is determined by the network status of the provider or facility that performs the x-rays or lab tests.

Certain procedures, such as surgery in a Doctor's office, are considered separate from the office visit. These expenses are subject to the calendar year deductible and payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

Preventive Care

The Plan covers periodic physical exams by a Doctor for a Member who is at least eight days of age. This includes x-ray and lab services if part of the annual physical exam, necessary immunizations and booster shots.

The Plan covers an annual pelvic exam, Pap smear and mammogram.

Preventive care x-rays and lab tests ordered as part of an Office Visit and performed in a Hospital are subject to the X-rays and Lab Tests "Hospital care" payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

Preventive care x-rays and lab tests ordered as part of an Office Visit and performed in a provider's office or independent x-ray and lab facility, are subject to the X-rays and Lab Test "Office Visit" payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

The Preventive Care x-rays and lab tests payment percentage is determined by the network status of the provider or facility that performs the x-rays and lab tests.

Post-Mastectomy Coverage

The Plan covers reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications related to all stages of mastectomy, including lymphedemas.

Treatment is to be determined by the attending Doctor, in consultation with the patient. Benefits will be payable on the same basis as for similar treatment covered under the Plan.

Reconstructive Services and Surgery

The Plan covers reconstructive services and surgery, including but not limited to treatment of covered newborn children's congenital defects and birth abnormalities, when the reconstruction meets **one** of the following primary purposes:

- When the primary purpose is to restore large skin defects due to a port wine stain.
- When the primary purpose is to relieve severe physical pain caused by an abnormal body structure.

- When the primary purpose is reconstruction following a mastectomy. See "Post-Mastectomy Coverage".
- When the primary purpose is to:
  - treat a functional impairment caused by an abnormal body structure; or
  - restore the Member's normal appearance, regardless of whether a functional impairment exists;

  when the abnormality results from a documented Illness that occurred within the preceding 12 months.

  Subsequent procedures integral or linked to the covered reconstruction that cannot be performed within the 12-month period due to medical considerations, may be covered after the 12-month period if documented planning for these procedures takes place within 12 months of the Illness.

  "Functional impairment" means an impairment that interferes with normal bodily function. For the purpose of this provision, interference with psychological function or well-being is not considered to be a functional impairment.

Certain types of reconstructive services and surgeries may not be covered under the Plan. See BENEFIT LIMITATIONS.

Neurodevelopmental Therapies

The Plan covers neurodevelopmental therapies for Dependents age six and under, and includes maintenance of a Member in cases where significant deterioration in the patient's condition would result without the service.

This includes expenses incurred for out-of-Hospital services of licensed speech and occupational therapists.

Maternity Coverage

The Plan includes Great Beginnings which is a Maternity Support Program (the GB Program) that will assist Members to identify the care they need during their pregnancy and avoid risks related to their pregnancy. Members who may benefit from the GB Program are identified through a variety of means, such as review of medical claims, preauthorization requests, physician referrals and self referrals. An enrolled Member will receive educational materials and a medical assessment. The care managers in the GB Program will work with the Member and the attending Doctor and provide the care and education necessary during the Member's pregnancy. If it is determined that there are complications and that the pregnancy will qualify as high risk, then the progress of the Member's pregnancy will be followed more intensely and care will be coordinated with the attending obstetrician and perinatologist. All information is confidential and will only be shared with those directly involved in your medical care.

There are no additional out-of-pocket expenses for these services obtained through the GB Program. If this Plan includes a Lifetime Maximum, then any costs associated with the Member's participation in the GB Program will be applied to the Maximum Benefit for All Covered Expenses.

The Plan covers prenatal, childbirth and postnatal care. Coverage for you and your baby, if dependent coverage is elected, includes a Hospital stay of 48 hours following a normal vaginal delivery and 96 hours following a C-section. The 48/96 hours begin following delivery of the last newborn in case of multiple-births. When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission. The Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for early discharge is made by the attending Doctor in consultation with the mother.

Facility charges for the inpatient Hospital stay are payable at the Hospital coinsurance amount shown in PPO MEDICAL BENEFITS SUMMARY.

For the purpose of this provision's length of stay periods, "Hospital" includes licensed birthing centers. A birthing center can be either an independent medical facility, or it can be a separate facility within a Hospital. A Hospital birthing room does ***not*** qualify as a birthing center, unless it is a separate facility. Be sure to check with the Hospital before your admission to confirm that it has a separate birthing center.

Facility charges at a licensed birthing center are payable at 100%, and are not subject to the calendar year deductible. Facility charges do not include your Doctor's charges. To receive 100% birthing center benefits, you must use a licensed birthing center.

Pre-authorization is not required for the 48/96-hour Hospital stay. However, authorization is needed for a longer stay than as described above.

Family Planning

The Plan covers tubal ligations and vasectomies, elective abortions and infertility testing.

Treatment of Chemical Dependency

The Plan covers treatment of alcoholism, drug addiction and other chemical dependency. This includes:

- Inpatient treatment during confinement for a Member in a Hospital or a Chemical Dependency Treatment Facility, as defined below. Inpatient treatment will include detoxification.
- Outpatient treatment for a Member in the outpatient department of a Hospital, in a Chemical Dependency Treatment Facility, or by a Doctor.

As used in this provision, the term:

- "Chemical Dependency Treatment Facility" means a facility which has been approved by the office or department responsible for granting approval of such facilities in the geographical area in which the treatment is rendered.
- "Chemical Dependency" means an Illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverage. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

The maximum benefit for any one period of 24 consecutive months may be reduced by the benefits paid by any plan for the treatment of chemical dependency in the immediately preceding 24 month period.

Treatment of Mental Health Conditions

The Plan covers inpatient and outpatient treatment of mental health conditions. This includes treatment in a Hospital, by a Doctor, or by a licensed psychologist.

A "Hospital" will include a facility which:

- Is a community mental health agency; or
- A state Hospital as defined in RCW 72.23.010; and
- Meets all requirements set by state law.

Spinal Adjustment and Treatment

The Plan covers expenses for services related to spinal adjustment.

Home Health Care

The Plan covers home health care visits when services are provided by a licensed home health care agency. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The Member must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time.

Hospice Care

The Plan covers hospice care if prescribed by a Doctor and the Member's life expectancy is six months or less.

Transplants

The Plan covers transplants that have been preauthorized by Medical Management.

Medical Management will direct the patient to the appropriate facility for the patient's specific type of transplant. Certain facilities, referred to as Great-West Healthcare Transplant Network facilities, have been selected as designated transplant facilities on the basis of improved patient outcomes for particular transplants.

Certain types of transplants must be performed in a Great-West Healthcare Transplant Network facility to be covered under the Plan. For more information, contact Member Services at the phone number or website address shown on the Member's ID card.

As used in this Transplant provision, the term "donor" means a person who furnishes an organ or tissue for transplantation. If a human organ or tissue transplant is provided from a donor to a transplant recipient, the following will apply:

- When the donor and recipient are both covered under this Plan - This Plan covers, under the recipient's coverage, eligible transplant expenses incurred by both patients.
- When only the recipient is covered under this Plan - This Plan covers eligible transplant expenses incurred by the recipient. Coverage may also be provided under this Plan for certain donor expenses, but only if such donor expenses are not eligible for coverage under any other coverage available to the donor.
- When only the donor is covered under this Plan - When the donor is covered under this Plan, but the recipient is not, this Plan does not cover transplant expenses of either person.

Any amounts paid under this Plan on behalf of a donor or a recipient will count toward the recipient's Plan lifetime maximum.

Travel Expenses

The Plan covers the following:

- Transportation costs and miscellaneous expenses such as lodging, meals and parking incurred for travel to and from a Great-West Healthcare Transplant Network facility, if the site is outside a 50-mile radius from the Member's home. Travel expenses must be preauthorized by Medical Management to be covered under the Plan.

  Travel expense coverage will be for the Member (the transplant recipient) and one other individual, or two other individuals if the transplant recipient is a minor, accompanying the Member. While there is no maximum limit to the number of days per trip, miscellaneous expenses such as lodging, meals and parking are limited to $100 per person, per day. Transportation expenses do not have a daily limit.

  Travel coverage, including transportation and miscellaneous expenses, is limited to the Transplant Travel Expenses Lifetime Maximum shown in PPO MEDICAL BENEFITS SUMMARY, not to exceed $100 total per person, per day.
- If a living donor is used, reimbursement for the donor's Travel Expenses to and from a Great-West Healthcare Transplant Network facility is limited to one trip and $100 per day for travel and lodging. All living donor travel and lodging charges apply to the Member's Transplant Travel Expenses Lifetime Maximum shown in PPO MEDICAL BENEFITS SUMMARY.

Travel expenses are not covered if the Member utilizes a facility other than a Great-West Healthcare Transplant Network facility.

Enteral Nutrition

Enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for the treatment of phenylketonuria (PKU).

The Plan covers enteral nutrition and supplies required for enteral feedings when ***all*** of the following conditions are met:

- It is necessary to sustain life or health;
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder;
- It requires ongoing evaluation and management by a Physician; and

- It is the sole source of nutrition or a significant percentage of the daily caloric intake.

Coverage ***does not*** include:

- Regular grocery products that meet the nutritional needs of the patient (e.g., over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products:
  - Prescribed without a diagnosis requiring such foods;
  - Used for convenience purposes;
  - That have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - Used as a substitute for acceptable standard dietary intervention; or
  - Used exclusively for nutritional supplementation.

Clinical Trials

Services and supplies, such as medications, provided as part of clinical trials are generally not covered under the Plan because they are Experimental, Investigational or Unproven.

However, the Plan covers clinical services, as defined in this provision, when a Member participates in a phase III or IV clinical trial that has been preauthorized by Medical Management for treatment of cancer or other life-threatening Illness, if all of the following criteria are met:

- the Member has a current diagnosis that will likely be terminal in less than two years under generally accepted treatment options in the absence of the clinical trial; and
- standard therapies have not been effective in significantly improving the condition or standard therapies are not medically appropriate; and
- the Member must be enrolled in the clinical trial and not be treated off protocol; and
- treatment is provided in a clinical trial that meets certain criteria established by Great-West Healthcare. For more information, contact Member Services at the phone number or website address shown on the Member's ID card.

All Plan provisions, including but not limited to pretreatment authorization and Medical Management review, apply to a Member's participation in a clinical trial.

For the purpose of this provision, "clinical services" mean services and supplies that are:

- necessary to administer the service or supply that is the focus of the clinical trial.
- necessary for management of the patient's health within the clinical trial.
- required for the clinically appropriate monitoring of the effects of the focus of the clinical trial (example: blood tests to measure tumor markers).
- required for the prevention, diagnosis or treatment of complications that result from the clinical trial treatment.

Clinical services do not include:

- services and supplies that:
  - are excluded from coverage under the Plan in absence of an approved clinical trial.
  - are customarily provided by the trial sponsor at no cost to the patient.
  - are provided solely to determine trial eligibility.
  - are provided solely to satisfy the trial's data collection needs (examples: monthly CT scans for a condition that usually requires a single scan, protocol induced costs).
- costs that are funded by other agencies or research sponsors.
- expenses such as travel, housing, companion expenses that may result from a Member's participation in a clinical trial.

- administrative services (example: statistical analysis).
- charges related to covered services or supplies that have not or cannot be separated from costs related to non-covered services or supplies.

<u>Other Medical Services and Supplies</u>

The Plan covers:

- Durable medical equipment, including orthopedic and prosthetic devices, not useful in the absence of an Illness or Injury, not disposable, able to withstand repeated use and appropriate for use in a Member's home.

  Coverage includes repair or replacement of covered equipment only when repair or replacement is required as a result of normal usage. Coverage for equipment rental will not exceed the equipment's purchase price.
- Nursing services.
- Air or ground ambulance when used to transport a Member:
  - from place of Illness or Injury to the nearest Hospital where appropriate treatment can be provided; and
  - from one Hospital to another, when approved by Medical Management.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.
- Custom-designed orthotics when prescribed by a Doctor and required for all normal, daily activities.
- Physical therapy rehabilitation to restore function and prevent disability following acute disease, Injury or loss of body part with the expectation of significant improvement within two months. Covered therapy includes exercise, heat, cold, electricity, ultrasound and massage to improve circulation, strengthen muscles, encourage return of motion and train Members to perform the activities of daily living.

  Massage is covered only when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.
- Treatment of Injury to sound/natural teeth within six months after the accident. "Sound/natural" means teeth that are free from defect or disease, and are not artificial. A chewing injury is not considered to be an Injury.
- Services required for the treatment of diabetes and diabetes self-management education programs.
- Outpatient Occupational, Speech and Hearing Therapy.

  Occupational therapy means rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, Injury or loss of body part with the expectation of significant improvement within two months. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.

  Speech therapy means restoration of speech due to impairment following a recent physiological disturbance or Injury, such as CVA, tracheostomy, swallowing disorders, laryngectomy and neuromuscular disease, with the expectation of significant improvement within two months.
- Medically approved formulas for the treatment of phenylketonuria (PKU).
- Second surgical opinions.

■ Is There a Limit On My Expenses?

The breakpoint maximums are shown in PPO MEDICAL BENEFITS SUMMARY.

PPO MEDICAL BENEFITS - Continued

Calendar Year Breakpoint

If in any one calendar year a Member's covered expenses reach the individual breakpoint, all other covered expenses for that Member during the rest of that calendar year, subject to the Member's payment of copays and satisfaction of the calendar year deductible, will be payable at 100%. No more than the individual breakpoint per Member will be applied to the family breakpoint.

Covered expenses for outpatient care of mental health conditions and chemical dependency treatment will ***not*** be payable at 100%, even if a Member has reached the breakpoint.

Expenses Excluded from the Breakpoint

Expenses that are not applied toward the breakpoint include expenses:

- for services and supplies not covered under this Plan.
- used to satisfy any deductible or copay amounts.
- for outpatient care of mental health conditions and chemical dependency.
- that are payable at 100%.

PRESCRIPTION DRUG BENEFITS

The prescription drug benefits are provided through several programs. The Performance Pharmacy Program uses a nationwide network of participating retail pharmacies. The Ninety-day Retail Network Pharmacy Program offers the convenience of obtaining a three-month supply of medication at designated retail pharmacies. The Mail Order Drug Program offers one mail order pharmacy that can dispense a multiple-month supply of medication and lowers a member's out-of-pocket costs. The Specialty Drug Program uses a small pharmacy network referred to as the Specialty Pharmacy Network (SPN). The SPN covers certain drugs commonly referred to as ***high-cost specialty drugs***.

The Tier 2 and Tier 3 drugs are subject to change. Contact Member Services or go to www.mygreatwest.com for additional information.

Covered drugs and contraceptive devices require the written prescription of a Doctor and approval by the Food and Drug Administration (FDA). Drugs and contraceptive devices must be purchased from a licensed pharmacist or Doctor. Benefits are payable only for drugs required for the treatment of Illness or birth control, when received as an outpatient and while covered for these benefits.

New FDA approved drugs are evaluated by the Pharmacy and Therapeutics Committee of your Plan's pharmacy benefit management company. Oversight and final decisions are made by the Great-West Healthcare Pharmacy Committee.

Some drugs may have dispensing limits that are primarily based on FDA recommendations. Additionally, some drugs are subject to prior authorization. Coverage for these drugs is dependent upon satisfying Medically Necessary requirements.

The Performance Pharmacy Program

The Performance Pharmacy Program covers charges for prescription drugs, insulin and diabetic supplies, except as specifically excluded under the Plan. Refer to Prescription Drug Benefit Limitations.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

The Performance Pharmacy Program covers a 30-day supply received in any one purchase.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. However, the brand name drug will be considered a covered expense if a generic drug is not available, or if the Doctor writes DAW (Dispense as Written) on the prescription. If the Member requests a brand name drug when a generic drug is available, and the Doctor has not written DAW on the prescription, then, in addition to the brand name drug copay, the Member must pay the difference between the cost of the generic drug and the brand name drug.

When a Member shows his/her ID card at a participating pharmacy, the pharmacist will collect the appropriate copay and the Member won't have to file a claim.

If a Member buys drugs at a pharmacy that is not a participating pharmacy, the Member must pay the pharmacist the full price of the drug and file a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost of the drug, minus the copay amount.

Ninety-day Retail Network Pharmacy Program

For convenience, a Member may elect to have a 90-day supply of maintenance medication filled at a designated retail pharmacy. This option is available **only** ***after the Member has filled a 30-day prescription for the same medication.*** To locate a retail network pharmacy that is equipped to fill a 90-day supply of medication, you may contact Member Services or access the website at www.mygreatwest.com. The minimum supply available under this benefit is an 80-day supply.

PRESCRIPTION DRUG BENEFITS - Continued

Mail Order Drug Program

The Mail Order Drug Program covers costs for home delivery and expenses for prescription maintenance drugs required for treatment of Illness. Prescription maintenance drugs are drugs prescribed by the Doctor on an ongoing basis. This includes expenses for diabetic supplies and insulin.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

With this program, a Member may buy through the mail up to 90-day supplies of insulin and covered maintenance prescription drugs. Ask the Employer for a mail order drug brochure.

Ask the Doctor to prescribe needed medications for a 90-day supply, plus refills. If a Member is presently taking medications, the Member should ask the Doctor for a new prescription.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. However, the brand name drug will be considered a covered expense if a generic drug is not available, or if the Doctor writes DAW (Dispense as Written) on the prescription. If a Member's prescription is for a brand name drug when a generic drug is available, and the Doctor has not written DAW on the prescription, then, in addition to the brand name drug copay, the Member must pay the difference between the cost of the generic drug and the brand name drug.

If medication is needed immediately, the Member should ask the Doctor for two prescriptions. The first should be for a 14-day supply that the Member can have filled at a local participating pharmacy. The second prescription should be mailed to the Mail Order Drug Program with the copay.

The Specialty Pharmacy Program

The Specialty Pharmacy Program covers certain drugs commonly referred to as ***high-cost specialty drugs***. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through a select group of pharmacies. These pharmacies comprise the Specialty Pharmacy Network (SPN). The SPN specializes in dispensing and delivering drugs that require special handling. Specialty Pharmacies provide additional helpful services, including free courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the specialty drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis.

With a new Specialty Pharmacy prescription, the Member may contact Member Services, or access www.mygreatwest.com, to identify the drugs contained on the Specialty Pharmacy list. Members may also access the website or contact Member Services for assistance in locating the Specialty Pharmacy that can be used to obtain medication.

Managed Drug Limit (MDL) Program

The MDL Program helps promote safe, clinically appropriate prescription drug use. With this program there is a limit on the dose amount and days' supply of certain medications. The limits for prescription drugs were developed based on recommendations by the Food and Drug Administration (FDA) and the manufacturer of the prescription drug. If a Doctor prescribes an additional supply of a prescription drug that is on the MDL list, the Pharmacy Prior Authorization (PPA) unit will review the request for Medical Necessity. If a Member has exceeded the limit, the Member must contact the Doctor or Member Services to initiate the authorization process with the PPA unit for additional supply of the prescription drug.

The Prior Authorization (PA) Program

The PA program helps to control the cost of prescription drug benefits by requiring certain high-cost drugs to be reviewed for Medical Necessity. This list is reviewed and updated periodically. The Member must make sure to contact their Doctor or Member Services to initiate the authorization process with the PPA unit for the high-cost drugs. To avoid any delay when filling prescriptions, a Member can call Member Services or access the Prior Authorization prescription drug list available at www.mygreatwest.com.

DENTAL BENEFITS

■ Allowable Covered Expenses

All dental benefits are subject to allowable covered expense guidelines.

The allowable covered expense is determined by usual and customary guidelines. The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a Dentist and the fee usually charged by other Dentists in the same geographical area for these services and supplies. The Member must pay any amount over usual and customary charges.

For specialist care and any other dental care expected to cost $300 or more, Members are encouraged to ask their Dentist to prepare a treatment plan and send it to the address shown on the ID card.

■ What's Covered?

DENTAL BENEFITS SUMMARY shows the payment percentage and deductible amount applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Services must be Medically Necessary for the diagnosis, prevention or correction of dental disease, defect or Injury. Services must be recommended or prescribed by a licensed Dentist or Doctor, or performed by a dental assistant or dental hygienist working under the direct supervision of a Dentist.

The Plan covers only the least costly procedure that will produce satisfactory results. Expenses are covered only if incurred and completed while a Member is covered for these dental benefits.

Preventive Care

Members may receive the following services twice each calendar year, but not more than once in any five-month period:

- Oral examination.
- Cleaning of teeth.
- Bite wing x-rays.
- Topical application of fluoride solution for Dependent children.

Preventive treatment also includes:

- Emergency exams.
- Sealants on molars every 36 months, for children to age 14; and
- A full-mouth series of x-rays once in any 24-month period.

Basic Care

Basic care includes:

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam, silicate, acrylic, and composite fillings. Silicate, acrylic, and composite fillings are covered only for teeth in front of the first bicuspid.
- Dental surgery.
- X-ray and lab services required for dental procedures.
- General anesthesia required for dental surgery.
- Care for relief of dental pain.
- Drugs that require a Dentist's written prescription, including medication given at the Dentist's office.
- Consultations required by the attending Dentist.
- Relines and rebases to existing dentures.
- For Members age 14 and under, habit-breaking appliances.

DENTAL BENEFITS - Continued

- For Members age 14 and under, space maintainers for missing primary teeth.
- Endodontic and Periodontic Care.

<u>Major Care</u>

Major care includes:

- Crowns, inlays and onlays.
- Fixed bridge restorations.
- Removable partial or complete dentures.
- Repairs to existing dentures.
- Certain types of implants and implant related services.
- Initial placement of full or partial dentures or bridgework, including abutments.
- Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:
  - The existing appliance cannot be repaired or restored to use; and
  - At least five years have passed since the last placement; or
  - The replacement:
    - Replaces an existing temporary appliance; and
    - Is placed within 12 months after a temporary appliance was placed; or
    - The replacement:
      - Is needed because of the pulling of additional natural teeth or Injury to natural teeth (except for chewing injuries); and
      - Is completed within 12 months of the extraction or Injury.

If a Member has a partial denture, and a natural tooth adjacent to that denture is pulled, the addition of another tooth to the Member's denture is covered.

VISION BENEFITS

A Member must be enrolled for medical coverage to be eligible for vision benefits. The Summary of Vision Benefits located in the front of the booklet shows the payment percentage applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Eye Exams

The Plan covers eye exams.

Eyeglass Lenses, Frames and Contact Lenses

The Plan covers eyeglass lenses, frames and contact lenses.

Maximum amounts payable include the cost of tinting, photograying and hardening of eyeglass lenses.

BENEFIT LIMITATIONS

Pre-Existing Conditions Limitation for Medical Benefits

This provision will ***not*** apply to a child placed with you for adoption.

A pre-existing condition is an Illness or any related condition for which a Member received services, supplies or medication during the 3 months before the enrollment date of the Member under this medical Plan.

A pre-existing condition is not:

- A pregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received 3 months after the enrollment date for the Member.

For a late applicant as described in "What If I Don't Apply On Time?", benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 3 months after the person's enrollment date.

"Enrollment date" means:

- the first day of coverage; or
- the first day of the eligibility waiting period, if an eligibility waiting period is required by the Employer.

You must apply for coverage for yourself and/or your eligible Dependents within the 31-day period when you are first eligible.

Portability of Coverage

A person will receive credit toward this Plan's Pre-Existing Condition Limitation periods for the time covered under another health plan, but only if the person was covered, under another health plan that meets the definition of "Creditable Coverage", within the 63-day period just before his or her enrollment date under this Plan. Any eligibility waiting period that the person must satisfy under this Plan will not be considered in determining the 63-day period. Creditable Coverage information is given to Great-West by the Employer. For questions regarding the amount of prior Creditable Coverage, contact the Plan Administrator.

If the person was covered:

- For a period of time under Creditable Coverage that is greater than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- For a period of time under Creditable Coverage that is less than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

  However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

Medical Benefit Limitations

No amount will be payable for:

- Services and supplies that are not Medically Necessary.
- Custodial care of a Member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or intercurrent health care needs.

  Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of:

  - walking, transferring or positioning in bed and range of motion exercises;

BENEFIT LIMITATIONS - Continued

  - self-administered medications;
  - meal preparation and feeding, by utensil, tube or gastronomy;
  - oral hygiene, skin and nail care, toilet use, routine enemas;
  - nasal oxygen applications, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.
- Special nursing services if those same services could be provided by the regular nursing staff of any Hospital in which the Member is confined.
- Charges by a Doctor for any phone call or interview during which the Member is not examined.
- Confinement, treatment, services or materials for educational or training problems or learning disorders.
- Outpatient physical, occupational or speech therapy for non-acute injuries, diseases or conditions that are not reasonably expected to result in significant clinical improvement within two months. This includes developmental progress in skills such as sitting, walking, talking and learning that compare unfavorably to measured results from standardized tests of others of the same age.
- Services or supplies which are primarily for the Member's education, training or development of skills needed to cope with an injury or sickness, except as specifically provided in the Plan.
- Any expense or charge, including any membership dues, associated with exercise equipment, health clubs, weight loss clinics or similar programs.
- Travel or transportation expenses, except as specifically provided in the Plan.
- Cosmetic, plastic or reconstructive services or surgery, except reconstructive services and surgery described in "What's Covered?".
- Gene manipulation therapy.
- The reversal of any sterilization procedure.
- Massage, except when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies provided in connection with or related to the surgery.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses. (See Vision Benefits section.)
- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants, or any treatment to improve the ability to chew or speak, unless otherwise covered under this Plan.
- Non-prescription/over-the-counter drugs or medicines, except as specifically provided under the Plan.
- Drugs or medicines that are not approved by the Food and Drug Administration (FDA).
- Programs related to smoking cessation.
- Osteotomy, orthognathic surgery, maxillofacial orthopedics or related treatment for deformities caused by anything other than cancer or trauma.
- Treatment for the purpose of weight loss, unless the Member is morbidly obese.
- Hearing aids or the fitting of hearing aids, including surgically implanted hearing aids.
- Treatment of temporomandibular disorders and craniofacial muscle disorders.
- Counseling, except as covered under the Plan's mental health and chemical dependency provisions.
- Drugs, medicines or insulin which are received as an outpatient.
- Any family planning procedure that requires surgical or drug assisted reproductive technology, such as, but not limited to, artificial insemination, in-vitro fertilization, GIFT or ZIFT, except necessary care and supplies needed to diagnose infertility.
- Infertility treatment.
- Chelation therapy, except to treat heavy metal poisoning.

BENEFIT LIMITATIONS - Continued

- Examinations or treatment ordered by a court in connection with legal proceedings when such treatment or examinations are not included as a covered expense under the Plan.
- Sex transformation procedures, services and supplies.
- Charges made by a Doctor for his or her time on "stand-by" status if he or she performs no actual services except for interventional cardiology procedures (such as angioplasty) and C-sections.
- Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's condition (e.g., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).
- Computerized speech devices or other adaptive equipment that is not primarily restorative in nature.
- Any charge not included as a covered expense under the Plan.
- Transplants, except as provided in the Transplant benefit provision. Non-human organs and Experimental, Investigational or Unproven transplant services and supplies, and any transplant expenses which are eligible to be paid under any private or public research fund, government program or other funding program, are not covered.
- Home delivery. Pre and postnatal care are covered expenses, but obstetrical services and medical expenses related to home delivery are not covered.
- Transcutaneous Electrical Nerve Stimulation (TENS) units.
- Enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except as specifically provided in the Enteral Nutrition benefits provision.
- Clinical trials, except as provided in the Clinical Trials benefit provision.

<u>**Prescription Drug Benefit Limitations**</u>

No amount will be payable for:

- Therapeutic devices and appliances, except as specifically provided under the Plan.
- Non-prescription/over-the-counter drugs and supplies, except as specifically provided under the Plan.
- Drugs or medicines that are not approved by the Food and Drug Administration (FDA).
- The administration of drugs.
- More than one purchase of a drug or insulin during the dosage period recommended by the prescribing Doctor.
- Allergy serums.
- Drugs for treatment of infertility.

<u>**Dental Benefit Limitations**</u>

No amount will be payable for:

- Dental appliances which have been lost, mislaid or stolen.
- Dental care that does not have ADA endorsement.
- Dental care provided to correct any birth defect or developmental malformation which does not interfere with function.
- Care of craniofacial muscle disorders and temporomandibular disorders.
- That part of any covered dental expense that is payable under any other provision of this booklet, unless:
  - Benefits are payable under both this dental benefit and any medical benefits; and
  - It is to the Member's advantage to have benefits paid under dental benefits rather than under medical benefits.
- Orthodontic treatment.
- Dental care that is cosmetic in nature.
- Services not necessary for the diagnosis, prevention or care of dental disease, defect or Injury.
- Dental care provided for dietary planning for the control of dental disease or for plaque control or for oral hygiene instructions.
- Customized dental procedures.

BENEFIT LIMITATIONS - Continued

- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.
- Take-home fluoride solutions.
- Local analgesics.

<u>Vision Benefit Limitations</u>

No amount will be payable for:

- Safety glasses.
- Radial keratotomy, lasik, laser and other refractive surgery.
- Medical or surgical treatment of the eye.
- Artificial eyes.

<u>General Benefit Limitations</u>

No amount will be payable for:

- Experimental, Investigational or Unproven services and supplies. Any service or supply that is integral or linked to an Experimental, Investigational or Unproven service or supply that, in the absence of the Experimental, Investigational or Unproven service or supply, would not be Medically Necessary, is also not covered.
- Vision therapy or orthoptic treatment.
- Anti-obesity drugs and formulas.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by your or your spouse's immediate or extended family.
- Care received for an Illness that is a result of war or engaging in a riot or insurrection.
- An Injury that occurs while working for pay or profit.
- An Illness for which the Member can receive benefits under any Workers' Compensation or similar law.

CLAIMS & LEGAL ACTION

■ How To File Claims

A claim for benefits and services that have been provided may be filed by a Member, beneficiary or Authorized Representative. An ***Authorized Representative*** means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment requests and appeals.

The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's condition will also be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

All claim forms include instructions on how to complete and submit a claim. Members can request a claim form from the Plan Administrator or go to www.mygreatwest.com to print a copy of a claim form. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

Health Benefits

Medical, Dental and Vision Benefits

Members who present their ID card when using a network provider will not have to file a claim. The ID card contains all the information network providers need to directly bill the Company for the balance.

For other services, Members must file a claim. Sign the completed form, attach the itemized bill and mail both to the address on the Member ID card.

An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

For expenses incurred outside the United States, the Member must pay the bill and file a claim.

Prescription Drug Benefits

A prescription given to a pharmacist is not a claim for benefits under the Plan. A Member may submit a claim for prescription drugs if:

- a copay amount was charged that the Member believes to be incorrect; or
- all or a portion of the cost of a prescription drug or supply is paid by the Member at the time the drug or supply is dispensed and the Member wants to request reimbursement for the amount paid; or
- prescription drugs or supplies are purchased at a pharmacy that is ***not*** a participating pharmacy.

Claim forms are available from Member Services and from the Employer. If a Member decides to pay full price to purchase a drug or supply, the Member should submit a claim to the prescription drug benefits manager for processing. Benefits will be processed subject to the provisions of the Plan. This includes any deductible, copayment percentage, coverage limitations and benefit maximums.

With the first Mail Order drug order, the Member should complete the member profile form found in the Mail Service brochure. Ask the Employer for a copy of this brochure.

Claim Decisions

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by Great-West. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and

- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the information is received within this time period, a decision will be made within 15 days of the date the information is received, unless the Member agrees to a longer period of time. If the requested information is not provided within this time period, the Member should consider the claim to be denied. The claim will be reconsidered if the information is subsequently received.

■ If A Claim Is Denied

If benefits are denied, in whole or in part, Great-West will send the Member a written or electronic notice within the established time periods described in "How to File Claims". The Member or Authorized Representative may appeal the denial as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

The notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

<u>Appeal of a Health Benefit Claim Denial</u>

After receiving notice of a claim denial, in whole or in part, the Member, the Member's beneficiary, provider or other Authorized Representative can appeal a claim denial by submitting a written request within:

- 180 days of the date the notice of denial of the initial claim is received; or
- 60 days of the date the notice of the initial appeal decision is received.

The appeal request must be submitted to Health Claim Appeal at the address on the adverse determination notice. The appeal request should include the Member's and the Employee's name and identification number, the date of service, address and telephone number of the Member and the provider, and a description of the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

In connection with the review, the Member has the right to:

- review and request copies of relevant documents, free of charge; and
- submit issues and comments in writing; and
- have a representative act on his or her behalf in the appeal.

The decision on the appeal will be made within 30 days of the date the appeal is received.

In the case of an adverse decision of an appeal, the notice of the decision will include the information described above for a claim denial.

Two appeals are required before the Member may bring civil action under ERISA Section 502(a) as described in the Statement of ERISA Rights.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

The Member has a right to request information regarding voluntary appeal procedures. Any statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending. Voluntary appeals do not need to be exhausted in order to bring civil action under ERISA Section 502(a).

For the purposes of health benefits, "medical judgment" includes but is not limited to Medically Necessity, and Experimental, Investigational or Unproven determinations.

Please see "How Does the Plan Work?" in MEDICAL BENEFITS for information about pretreatment authorization, urgent care and non-urgent care denials and appeals.

■ What If a Member Has Other Health Coverage?

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee's spouse's employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

This COB provision does not apply to your Prescription Drug Benefits.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;
- Any other group health plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile no-fault insurance plan.

<u>Which Plan Is Primary?</u>

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
  - the plan of the parent whose birthday falls earlier in a year will be primary; but
  - if both parents have the same birthday, the plan that covered the parent longer will be primary.

  However:

  - If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
  - If the parents are legally separated or divorced, benefits for the child will be determined in this order:
    * first, the plan of the parent with custody of the child will pay its benefits;
    * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
    * finally, the plan of the parent not having custody of the child will pay its benefits.

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.

- A plan that covers a person as:
  - a laid-off or retired employee; or
  - a Dependent of such an employee; or
  - a continuee under a state or Federal law;

  will determine its benefits after the benefits of any other plan covering that person as an employee.

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
  - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
  - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if there were no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% rather than partial payment of allowable expenses that are incurred by the same person within the same calendar year.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

■ How Will Benefits Be Affected By Medicare?

The following applies to you if you are an active Employee and you or your spouse becomes eligible for Medicare **due to age.** You and your Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then this medical Plan will be considered the Member's primary coverage, and Medicare will be considered the Member's secondary coverage. This means that benefits under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then Medicare will be considered primary, and this medical Plan will be considered secondary.

The following applies to you if you are an active Employee and you or your Dependents become eligible for Medicare **due to disability.** You and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then coverage under this medical Plan will be considered the primary coverage, and Medicare will be considered the secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, Medicare will be considered the primary coverage, and coverage under this Plan will be considered the secondary coverage.

<u>If A Member Becomes Eligible for Medicare Due to End-Stage Renal Disease (ESRD)</u>

Under Medicare law, a Member must complete a waiting period, typically three months, before becoming eligible for Medicare solely because of ESRD. During this waiting period, this Plan will pay benefits and Medicare will not pay any benefits.

After the waiting period, for the first 30 months of eligibility for Medicare Part A benefits solely due to ESRD, this Plan will pay its benefits first (primary payer) and Medicare will pay its benefits second (secondary payer). After that, if the Member is still eligible for Medicare due to ESRD, Medicare will be the primary payer and this Plan will be the secondary payer.

In certain circumstances, such as a kidney transplant, the 30-month time frame that this Plan will be the primary payer may be less as defined by the Medicare guidelines for determining primary payer.

If the Member becomes eligible for Medicare due to ESRD after Medicare became the primary payer under any other provision of Medicare law or this Plan, Medicare will be the primary payer and this Plan will be the secondary payer.

Treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan.

A Member is eligible for Medicare when:

- the Member is covered under Medicare; or
- the Member is not covered under Medicare due to:
  - the Member's refusal of Medicare coverage;
  - the Member's voluntary termination of Medicare coverage; or
  - the Member's failure to apply for Medicare coverage.

<u>If You Are A Retired Employee</u>

If you are a Retired Employee age 65 or over, then any medical benefits payable under this Plan for you (and for your spouse if he or she is age 65 or over) will be directly reduced by the amounts payable for the same expenses under Parts A and B of Medicare. This means Medicare will pay benefits first and will be known as the primary payer of benefits. Medicare age Members will be considered to be enrolled under both Parts A and B of Medicare whether or not they are actually enrolled.

■ Provision for Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a Workers' Compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, Great-West may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to Great-West any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with Great-West in asserting its subrogation and recovery rights. The Covered Person will, upon request from Great-West, provide all information and sign and return all documents necessary to exercise Great-West's rights under this provision.

Great-West will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by Great-West for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. Great-West will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

No Covered Person shall make any settlement which specifically reduces or excludes, or attempts to exclude, the benefits provided by the Plan.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse Great-West for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to Great-West for the amount of the benefits paid under this Plan; and
- Great-West may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

CLAIMS & LEGAL ACTION - Continued

Great-West's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or
- on behalf of any incapacitated person.

■ Other Information a Member Needs to Know

Proof of Claim

Send written claim to Great-West as soon as reasonably possible. A Member must submit a written claim no later than 15 months from the date the claim is incurred, unless legally incapable of doing so.

Complaint Process

For concerns or complaints, contact Member Services at the phone number shown on the ID card. Whether the issue involves health care or the administration of coverage, Great-West's representatives will do what they can to make sure it's addressed. No retaliatory action will be taken by Great-West against the Member because of a complaint. Great-West's goal is for the Member to be completely satisfied with the measures taken to resolve the issue. However, if a Member is not satisfied, Great-West's representatives can help the Member begin the formal complaint process. If the issue is not resolved to the Member's satisfaction, the Member may appeal.

For complaints involving timely claim payment or a denial of a claim see "How To File Claims". For complaints involving a preauthorization determination, see "Medical Management (MM) Program" in MEDICAL BENEFITS.

For all other complaints, including those related to availability, delivery or quality of a health care service, contact Member Services for an explanation of the complaint process.

Legal Actions

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Physical Examinations

The Company, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

Benefit Payments

Benefits will be paid to the Member, if living. If not, benefits will be paid to the Member's estate. If any benefit is payable to the Member's estate or to a person who cannot give a valid release, then Great-West can pay up to $1,000.00 to any relative it considers to be entitled to such payment. The Member may request in writing that payments under the Plan be made directly to the person providing the services.

Benefit Payments to a Representative of a Minor

In the case of a minor child who qualifies as a Dependent under the Plan, if the child has a representative who is not covered under the Plan, then the Plan must pay benefits on behalf of that child to the representative. The person must submit proof that he or she is the child's representative and that he or she qualifies to be paid the benefits.

CLAIMS & LEGAL ACTION - Continued

Relationship Between Great-West and Network Providers

Providers under contract with Great-West are independent contractors. Network providers are neither agents nor employees of Great-West, nor is Great-West, or any employee of Great-West, an agent or employee of Network providers. Great-West will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

GLOSSARY

<u>Creditable Coverage</u>

Coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools, the Federal Employee Health Benefit Plan (FEHBP) or a State Children's Health Insurance Program (S-CHIP).

<u>Dentist</u>

A person licensed to practice dentistry.

<u>Dependent</u>

See ELIGIBILITY.

<u>Doctor/Physician</u>

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts including but not limited to a Dentist, chiropractor, optometrist, psychologist, acupuncturist, naturopath and Master of Social Work (MSW) if:

- He or she performs a service within the scope of his or her license and for which this Plan provides coverage; and
- State law requires such practitioner to be covered.

<u>Emergency Medical Condition</u>

The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson who possesses an average knowledge of health and medicine to believe that immediate medical care is required and that lack of such care could reasonably be expected to result in:

- placing the patient's life in serious jeopardy;
- serious Injury or impairment of bodily functions; or
- serious or permanent dysfunction of any bodily organ or part;
- with respect to a pregnant woman, placing the woman's health, or that of her unborn child, in serious jeopardy.

<u>Employee</u>

See ELIGIBILITY.

<u>Employer</u>

- The Board of Trustees of Whitman College; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

<u>Experimental, Investigational or Unproven</u>

A service or supply, such as medication, that meets any of the following criteria:

- For a service or supply that is subject to Food and Drug Administration (FDA) approval:
  - it does not have FDA approval; or
  - it has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use.

  An accepted off-label use is a use that is:
  - established based on reliable evidence as defined in this provision; or
  - is included and favorably recognized for treatment of the indication in at least one of the following publications: DrugDex, Drug Facts and Comparisons, Clinical Pharmacology or other established reference compendia as designated by Medical Management, and the data are sufficiently conclusive as to efficacy to allow recognition of the off-label use; or

- Is being provided pursuant to phase I, II, III or IV clinical trials, unless in the case of phase III or phase IV clinical trials is provided in accordance with the clinical trials coverage described in the Plan; or
- Is being provided pursuant to a written protocol that describes among its primary objectives determination of maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
- Is being provided pursuant to a written informed consent used by the treating provider that refers to the service or supply as experimental, investigational, unproven or for research; or
- Is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the Department of Health & Human Services (HHS) and the FDA; or
- Based upon review and analysis of the published peer-reviewed medical or dental literature, the weight of the evidence demonstrates that it is the predominant opinion of independent experts that the service or supply:
  - is substantially confined to use in research settings; or
  - is subject to further research studies or clinical trials, in order to determine maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
  - is experimental, investigational, unproven; or
- Is not a covered service or supply as defined under Medicare because it is considered investigational or experimental as determined by HHS/Centers for Medicare & Medicaid Services (CMS); or
- Is not currently the subject of active investigation because prior investigations and/or studies have failed to established proven efficacy and/or safety.

In making the determination whether a service or supply is Experimental, Investigational or Unproven, Medical Management reserves the right to certify coverage of a service or supply, notwithstanding that the service or supply meets one of the above criteria, if there is reliable evidence as defined in this provision, that would support use of the service or supply as efficacious in the unique circumstances present in a particular case.

For these purposes, “reliable evidence” means evidence of all of the following:

- There are at least two articles in peer-reviewed U.S. scientific medical or pharmaceutical publications supporting use of the service or supply outside the investigational setting; and
- The published articles evidence a well-designed investigation that has been reproduced by non-affiliated authoritative sources with measurable, clinically meaningful results; and
- The investigation evidences that the probable benefits of using the service or supply in the unique circumstances in the particular case in question outweigh the risks associated with such use in situations where conventional alternatives have not or would not be efficacious.

Hospital

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Illness

An Injury, a sickness, a disease, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

GLOSSARY - Continued

Loss of Residence

Being outside the United States for more than 365 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 365 continuous days.

Medically Necessary/Medical Necessity

Health care services and supplies, such as medication, that a Physician or Dentist, exercising prudent clinical judgment, provides to a Member for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and are:

- In accordance with generally accepted standards of medical or dental practice; and
- Clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Member's Illness, Injury or disease; and
- Not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Plan; and
- Specifically allowed by the licensing statutes which apply to the Physician or Dentist who provides the service or supply; and
- At least as medically effective as any standard care and treatment; and
- Not primarily for the convenience, psychological support, education or vocational training of the Member, Physician, Dentist or other health care provider; and
- Not more costly than an alternative service, supply or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical or dental practice" mean the:

- Standards that are based on credible scientific evidence published in peer-reviewed medical and dental literature generally recognized by the relevant medical and dental community;
- Recommendations of an American Medical Association-recognized Physician specialty society or of an American Dental Association-recognized Dentist specialty society;
- Prevalent practices of Physicians or Dentists in the relevant clinical area; or
- Any other relevant factors.

Medical Management may require satisfactory proof in writing that any type of service or supply received is Medically Necessary. Medical Necessity will be determined solely by Medical Management, in accordance with the definition above.

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare Advantage plans.

Member

An Employee and any covered Dependent.

Plan

The medical, prescription drug, dental and vision benefits described in this booklet.

Retired Employee

See ELIGIBILITY.

GLOSSARY - Continued

<u>Service</u>

See ELIGIBILITY.

<u>Totally Disabled and Total Disability</u>

Active Employees

Being under the care of a Doctor and prevented by Illness from performing your regular work.

Dependents and Retired Employees

Being under the care of a Doctor and prevented by Illness from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

<u>You and Your</u>

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the medical, prescription drug, dental and vision coverage that you (the Employee) had in effect for yourself and your Dependents.

"Uniformed Service" means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Continued Medical, Prescription Drug, Dental and Vision Coverage

Under USERRA, you are eligible to elect continued medical, prescription drug, dental and vision coverage for yourself and your Dependents when you terminate Service with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued medical, prescription drug, dental and vision coverage and for payment of contributions. See the Plan Administrator for details.

If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service.

However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Employer's reasonable procedures.

If you provide advance notice of your leave but you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

If you elect continued coverage but do not make timely payments for the cost of coverage

If the Employer has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures.

Period of Continued Coverage

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

Cost of Continued Coverage

USERRA RIGHTS AND RESPONSIBILITIES - Continued

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage.

If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage.

COBRA Coverage

If you are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

For medical coverage, a pre-existing condition limitation may be imposed on an Illness that is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, Uniformed Service. See the Plan Administrator for details.

CONTINUATION OF COVERAGE - FMLA

If the Employer approves your FMLA leave pursuant to the Family and Medical Leave Act of 1993 (FMLA), coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. However, a COBRA qualifying event does not occur unless you do not return to work on the date you are scheduled to return from your FMLA leave. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about FMLA leave, see the Plan Administrator.

CONTINUATION OF COVERAGE - COBRA

This provision generally explains COBRA continuation coverage, when it may become available to a Member and what a Member needs to do to protect the right to receive it. COBRA continuation coverage, is a temporary extension of coverage under the Plan, and was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

In some circumstances, COBRA requires that Members who lose group Medical, Prescription Drug, Dental and Vision plan coverage to be given an opportunity to continue that coverage when there is a "qualifying event" that would result in a loss of coverage under the Plan. A "qualified beneficiary" is a person who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, qualified beneficiaries can include the Employee and/or the Employee's spouse, Dependent children or Domestic Partner. COBRA continuation coverage must be offered to each qualified beneficiary and the coverage is the same coverage that other Members under the Plan who have not had a qualifying event have. Each qualified beneficiary will have the same rights under the Plan as other Members, including open enrollment and special enrollment rights.

<u>Right to COBRA Continuation Coverage</u>

- As an Employee, you have a right to choose COBRA continuation coverage, if you lose your coverage due to a reduction in your hours of employment, or due to voluntary or involuntary termination of your employment, for any reason except gross misconduct.
- As a Dependent spouse, you have the right to to choose COBRA continuation coverage, if you lose your coverage due to the Employee's death, or the Employee's termination of employment or reduction in hours of employment, as stated above, or due to your divorce or legal separation. If the Employee cancels your coverage in anticipation of your divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you have lost coverage earlier.
- Your Dependent Child, including alternate recipients under a medical child support order and your Domestic Partner have the right to choose COBRA continuation coverage if the Dependent Child or Domestic Partner loses coverage due to the reasons stated above or ceases to be an eligible Dependent under the terms of the Plan.
- As a retired Employee, in addition to COBRA continuation rights as stated above, you have a right to choose COBRA continuation coverage, if you lose your coverage due to and within one year before or after the Employer's filing a proceeding in bankruptcy under Chapter 11 of the Bankruptcy Code. Your eligible Dependents will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

<u>Length of COBRA Continuation Coverage</u>

Generally:

- In the case of loss of coverage due to termination of employment or reduction in hours of Service, coverage may be continued for those who elect continuation coverage, for up to 18 months from the date of loss of coverage.
- In the case of loss of coverage due to your death, divorce or legal separation, or a Dependent Child or Domestic Partner ceasing to be a Dependent under the terms of the Plan, coverage may be continued for those who elect continuation coverage, for up to 36 months from the date of such event.
- If an Employee becomes entitled to Medicare and later has a qualifying event, which is a termination of employment or reduction of hours, within 18 months of entitlement to Medicare, then the maximum coverage period for the Dependent spouse and children or Domestic Partner will be 36 months which begins from the date the Employee becomes entitled to Medicare.
- With respect to Members qualified for COBRA continuation coverage due to the Employer's bankruptcy filing as described above, those who lose coverage may elect continuation coverage. The coverage will continue for up to:
  - the date of your death, if you are retired; or
  - the date of the surviving spouse's or Domestic Partner's death; or
  - 36 months after your death if your Dependent elected COBRA continuation coverage.
- If, after the occurrence of any event described in the Right to COBRA Continuation Coverage above, the Member is allowed to continue coverage under the Plan (whether or not contributions are required) beyond the Plan's termination of coverage provision for any reason other than to comply with the federal law (i.e. state laws mandating continuation coverage or the Plan's special provisions), such continuation period(s) will be used to reduce the maximum length of COBRA continuation coverage period otherwise available to such person under this provision.

<u>Extension of COBRA Continuation Coverage</u>

- ***Disability Extension*** - If you lose coverage because of termination of your employment or reduction in your hours of employment, and if anyone in your family unit is determined under Title II or XVI of the Social Security Act to have been Totally Disabled at any time during the first 60 days of COBRA continuation coverage, then the Totally Disabled Member and other qualified beneficiaries who are entitled to COBRA continuation coverage may extend the continuation for 11 additional months.
- ***Second Qualifying Event*** - If your Dependent:
  - is covered under COBRA because of termination of your employment or reduction in your hours of employment; and
  - while covered under COBRA experiences a second qualifying event, such as a divorce or legal separation or ceasing to be an eligible Dependent;

then such qualified beneficiaries are entitled to up to a maximum of 36 months of COBRA coverage from the date of the first qualifying event.

Health FSA

The maximum COBRA coverage period for a health flexible spending arrangement (Health FSA), if maintained by your Employer, ends on the last day of the Flexible Benefits Plan Year in which the qualifying event occurred.

Notice Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator of the Employer or the representative of the Employer has been timely notified that a qualifying event has occurred.

When the qualifying event is termination of employment, reduction of hours of employment, death of the Employee or commencement of a proceeding in bankruptcy (applicable only to covered Retired Employees and their Dependents), the Plan Administrator will notify the Employee within 44 days of the later of the date of the qualifying event or the date coverage ends.

Dependents - If your spouse or Dependent children or Domestic Partner become eligible for COBRA continuation coverage due to divorce or legal separation or end of dependency status, or upon occurrence of a second qualifying event, the Plan Administrator or the representative of the Employer must be notified within 60 days of the first or the second qualifying event. The notice must be provided following Reasonable Notice Procedures, as described below.

If the notice is not provided within 60 days of the qualifying event, your spouse or Dependent children or Domestic Partner will lose the right to such coverage.

If you have a child or adopt a child while covered under COBRA, and you decide to add the child to your COBRA continuation coverage, then you must notify the Plan Administrator or the representative of the Employer of the birth or adoption within the 30 days of birth, adoption or placement for adoption in order for the child to be considered a COBRA qualified beneficiary. The notice must be provided following Reasonable Notice Procedures, as described below.

Disability Extension - A Member who wishes to continue COBRA continuation coverage under the Disability Extension must notify the Plan Administrator or the representative of the Employer of the Social Security Administration's disability determination within 60 days of such determination and before the end of the initial 18-month COBRA coverage period. If the notice is not provided within the specified timeframe, the qualified beneficiary and the members of the family unit will lose the right to extend COBRA coverage under the Disability Extension.

If the Social Security Administration determines that the qualified beneficiary's disability ceases to exist, then the qualified beneficiary must notify the Plan Administrator or the representative of the Employer of this information within 30 days of such determination.

The notice must be provided following the Reasonable Notice Procedures, as described below.

Reasonable Notice Procedures

Any notice that needs to be provided must be in writing. Oral notice, including notice by telephone, is not acceptable. The qualified beneficiary must mail the notice to the contact person at the address specified below:

Cindy Waring
345 Boyer Avenue
Walla Walla, WA
99362

The notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name and address of the Employee covered under the Plan and the names and addresses of the qualified beneficiaries, the qualifying event and

the date of the qualifying event. If a qualifying event is a divorce, the notice must include a copy of the divorce decree. In case of a disability, the notice must include the name of the disabled qualified beneficiary, the date of disability and a copy of the Social Security Administration's letter of determination of disability or determination that the qualified beneficiary is no longer disabled. The notice must be provided by the qualified beneficiary, spouse or parent, if applicable, or by an authorized representative of the qualified beneficiary.

Election of COBRA Continuation Coverage

When a qualifying event occurs, the Employer or a representative of the Employer must give the qualified beneficiary the necessary COBRA election form. The qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice or the date the qualified beneficiary would lose coverage, whichever is later. To elect coverage, the qualified beneficiary must follow the procedures specified in the Election Form. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If the qualified beneficiary does not elect coverage within the 60-day election period, the qualified beneficiary will lose the right to elect COBRA continuation coverage. The qualified beneficiary has the right to change a prior rejection of COBRA continuation coverage anytime within the 60-day election period by following the procedures specified in the Election Form. Failure to continue this coverage will affect future rights under federal law, such as the right to purchase individual health insurance policies that do not impose a pre-existing condition exclusion.

Cost of Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the applicable group rate.

If a qualified beneficiary elects to continue coverage, the qualified beneficiary must make the first payment for continuation within 45 days of the election. The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the qualified beneficiary fails to make the first payment, they will lose the continuation coverage rights under the Plan. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the qualified beneficiary makes the first payment for continuation coverage, they will be required to pay for continuing the coverage for each subsequent month of coverage; they will be given a grace period of 30 days to make each periodic payment. The coverage will be continued as long as payment for that period is made before the end of the grace period.

The Plan may require payments of up to 150% of the applicable group rate if coverage is extended under the ***Disability Extension***.

Termination of COBRA Continuation Coverage

The COBRA continuation coverage may terminate before the maximum period of continuation runs out if:

- The required contribution is not paid; or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare benefits (except for a person whose continuation coverage right derives from the Employer's filing for reorganization under Chapter 11 of the Bankruptcy Code); or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition limitation for a pre-existing condition of a qualified beneficiary; or
- After the date the qualified beneficiary qualifies under the ***Disability Extension***, the beneficiary is no longer disabled; or
- All of Employer's group health plans are terminated.

The qualified beneficiary must notify the Employer or its representative of the beneficiary's entitlement to Medicare coverage under another group health plan or that the beneficiary is no longer disabled within 30 days of the event. The notice must comply with the Reasonable Notice Procedures, described above. The Employer or its representative will notify the qualified beneficiary of the termination of coverage if it happens prior to the maximum period of COBRA continuation coverage.

CONTINUATION OF COVERAGE - COBRA - Continued

For more information about COBRA continuation of coverage, a Member may 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.

In order to protect your rights and your Dependent's rights, you should keep the Plan Administrator informed of any changes in the address of family members.

The Trade Act of 2002

The Trade Act of 2002 created special second COBRA election period for certain displaced workers receiving Trade Adjustment Assistance (TAA) under the Trade Act of 1974. A Member who did not elect COBRA continuation coverage during the initial 60-day election period that was a direct consequence of the TAA-related loss of coverage, may elect COBRA continuation coverage during a second 60-day period that begins on the first day of the month in which the Member is determined to be "TAA-Eligible". The election must be made within 6 months after the date of the TAA-related loss of coverage.

Under the new tax provisions eligible individuals can either take a tax credit or get advance payment of 65% of contributions paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282.

SECTION II - ERISA

ERISA GENERAL INFORMATION

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Sponsor/Employer is The Board of Trustees of Whitman College.

The address of the Plan Sponsor/Employer is 345 Boyer Avenue, Walla Walla, WA 99362. The telephone number is 509-527-5172.

The Employer Identification Number (EIN) is 91-0567740. The Plan Number assigned by the Plan Sponsor is 507.

The Plan Administrator is Cindy Waring, Director of Administrative Services.

The Agent for Service of Legal Process is the Plan Trustee or the Plan Administrator.

The Plan provides Medical, Dental, Prescription Drug and Vision Benefits.

The medical, prescription drug, dental and vision benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Great-West processes claims and provides other services to the Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

Great-West Life & Annuity Insurance Company provides Contract Administration.

The eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The fiscal records of the Plan are maintained on the basis of Plan years ending December 31.

Procedures to be followed in presenting claims for medical, prescription drug, dental and vision benefits and what to do when claims are denied in whole or in part are described in "How To File Claims" under the MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS SECTION of this booklet.

STATEMENT OF ERISA RIGHTS

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

- Receive Information About Your Plan and Benefits.

  You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and 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.

  You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

  - You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

  However, Employers with fewer than 100 Participants at the beginning of the Plan Year are not required to:

  - **furnish statements of the plan's assets and liabilities and receipts and disbursements or allow examination of the Annual Report; or**
  - **furnish copies of the Annual Report or any Terminal Report.**

STATEMENT OF ERISA RIGHTS - Continued

- Continue Group Health Plan Coverage.

  You may be eligible to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. You may review this summary plan description and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.

  There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (up to 18 months if you are a late enrollee) after your enrollment date in your coverage.
- Prudent Actions by Plan Fiduciaries.

  In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your 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. 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.
- Enforce Your Rights.

  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 without charge copies of documents relating to the decision 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 Plan 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 $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 Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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.
- Assistance With Your Questions.

  If you have any questions about your Plan, you should contact the 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 Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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.

Arranged by:

Parker Smith & Feek

Phone Number: 1-800-457-0220