

WHITMAN COLLEGE

Your Choice™

1038127

INTRODUCTION

This plan is self-funded by Whitman College, which means that Whitman College is financially responsible for the payment of plan benefits. Whitman College ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

Whitman College has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross and Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. Whitman College has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent stated in our administrative services contract with the Group. Premera Blue Cross doesn't insure this plan. In this booklet Premera Blue Cross is called the "Claims Administrator." This booklet replaces any other benefit booklet you may have.

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

Group Name: Whitman College

Effective Date: January 1, 2012

Group Number: 1038127

Plan: Your Choice (Non-Grandfathered)

Certificate Form Number: WC2012YC

HOW TO USE THIS BOOKLET

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

- **How Does Selecting A Provider Affect My Benefits?** — how using network providers will cut your costs
- **What Types Of Expenses Am I Responsible For Paying?**
- **What Are My Benefits?** — what's covered and what you need to pay for covered services.
- **What's Not Covered?** — services that are either limited or not covered under this plan
- **Who Is Eligible For Coverage?** — eligibility requirements for this plan
- **How Do I File A Claim?** — step-by-step instructions for claims submissions
- **Your Ideas, Questions, Complaints And Appeals** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: "You" and "your" refer to members under this plan. "We," "us" and "our" refer to Premera Blue Cross.

FOR MORE INFORMATION

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

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

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

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

You can use our Web site to:

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

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HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

To help you manage the cost of health care, the Group has made use of our provider networks and our provider network arrangements with Blue Cross and/or Blue Shield Licensees throughout the country to furnish covered services to you through their provider networks. These networks consist of hospitals and other health care facilities, physicians and professionals. Throughout this section of your booklet, you will find important information on how to manage your health care costs and out-of-pocket expenses through your choice of providers.

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

The benefits of this plan will be provided for covered emergency services without the need for any prior authorization determination and without regard as to whether the health care provider furnishing the services is a network provider. Care furnished by a non-network provider will be reimbursed on the same basis as a network provider. If you see a non-network provider, you are always responsible for any amounts that exceed the allowable charge.

This plan's benefits are designed to provide lower out-of-pocket expenses when you receive care from network providers. (There are some exceptions explained in "In-Network Benefits For Non-Network Providers" later in this section.) The provider networks are different depending upon the state in which you receive care.

Throughout this booklet, the term "network" refers to the following provider networks:

State	Provider Type
Washington	The Premera Blue Cross Heritage network. In Clark County, Washington, you also have access to providers through the BlueCard Program. See "All Other States" later in this list.
Alaska	Providers who have contracts with Premera Blue Cross Blue Shield of Alaska
Wyoming	The local Blue Cross and/or Blue Shield Licensee's Traditional (Participating) network.

All other states The local Blue Cross and/or Blue Shield Licensee's PPO (preferred) network.

Participating pharmacies are also available nationwide.

Throughout this booklet, "non-network provider" refers to a provider who is not in the applicable network shown above.

This booklet refers to the benefits payable to network providers as "in-network" benefits and the benefits payable to non-network providers as "non-network" benefits.

Important Note: You access network providers in Clark County, Washington and in states other than Washington and Alaska through the BlueCard Program. See "BlueCard Program And Other Inter-Plan Arrangements" later in this booklet for more information about how BlueCard works.

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

For the most current information on network providers in Washington or Alaska, please refer to our Web site or contact Customer Service. You can call the BlueCard provider line to locate a network provider. You'll find our Web address and these phone numbers listed on the back cover of this booklet.

HOW SELECTING A PROVIDER AFFECTS YOUR OUT-OF-POCKET EXPENSES

You'll always get the highest level of benefits and lowest out-of-pocket costs when you get covered services from a network provider. If the provider you see is a network provider (as defined above), the provider agrees to accept the allowable charge as payment in full. (Please see the "Definitions" section of this booklet for an explanation of the allowable charge.) You're responsible only for applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies.

If the provider you see is a non-network provider, you'll get the lowest level of benefits under this plan for covered services and supplies, except as stated below. You'll also be responsible for amounts above the allowable charge, in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. Amounts in excess of the allowable charge do not count toward the calendar year deductible, if any, or as coinsurance.

In-Network Benefits For Non-Network Providers

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

- Emergency care. If you have a "medical emergency" (please see the "Definitions" section in this booklet) this plan provides worldwide coverage.
- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington or Alaska from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a network provider who doesn't have admitting privileges at a Washington or Alaska network hospital.
- Covered services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

Important Note: Services you receive in a network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are non-network providers. When you receive services from these non-network providers, you will be responsible for amounts over the allowable charge. Amounts in excess of the allowable charge don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Please see the "Benefit Level Exceptions For Non-Emergent Care" section for more information on how to request in-network benefits for services other than those listed above from non-network providers.

BENEFIT LEVEL EXCEPTIONS FOR NON-EMERGENT CARE

A "benefit level exception" is the plan's decision to provide in-network benefits for covered services from a non-network provider.

You, your provider, or the medical facility may ask us for the benefit level exception. However, the request must be made before you get the service or supply. If the request is approved, benefits for covered services and supplies will be provided at the in-network benefit level. Payment of your claim will be based on your eligibility and benefits available at the time you get the service or supply. You'll be responsible for amounts applied toward applicable deductibles, copays, coinsurance, amounts that

exceed benefit maximums, amounts above the allowable charge, and charges for non-covered services. If the request is denied, in-network benefits won't be provided.

Please call Customer Service at the phone numbers shown on the back cover of this booklet to request a benefit level exception.

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

This section of your booklet explains the types of expenses you must pay for covered services before the benefits of this plan are provided. To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for. You'll find the dollar amounts for these expenses and when they apply in the "What Are My Benefits?" section.

COPAYMENTS

Copayments (hereafter referred to as "copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service.

The copays applicable to the "Medical Services" portion of this plan are located under the "What Are My Copays?" provision in the "What Are My Benefits?" section later in this booklet. Any benefits that are subject to different copays will state those amounts in the benefit.

After your copay, benefits subject to a copay aren't subject to your deductible, coinsurance, or out-of-pocket maximum, if any.

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the "allowable charge" (please see the "Definitions" section in this booklet).

Individual Deductible

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

Family Deductible

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

member's individual deductible will count toward the family deductible.

The calendar year deductible amounts applicable to the "Medical Services" portion of this plan are located under the "What Are My Benefits?" section.

What Doesn't Apply To The Calendar Year Deductible?

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

- Amounts that exceed the allowable charge
- Charges for excluded services
- Copays
- The coinsurance stated in the Prescription Drugs benefit

COINSURANCE

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

The coinsurance percentage applicable to the "Medical Services" portion of this plan is located under "What's My Coinsurance?" in the "What Are My Benefits?" section. Any benefits that are subject to a different coinsurance percentage will state that percentage in the benefit.

OUT-OF-POCKET MAXIMUM

Individual Out-of-Pocket Maximum

The "individual out-of-pocket maximum" is the maximum amount, made up of the calendar year deductible and coinsurance, that each individual could pay each calendar year for certain covered services and supplies. This maximum applies to both in-network and non-network providers' services and supplies.

Family Out-of-Pocket Maximum

Once the family deductible is met, your individual deductible will also be satisfied. However, you must still pay coinsurance until your individual out-of-pocket maximum is reached.

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

Please refer to "What's My Out-of-Pocket Maximum?" in the "What Are My Benefits?" section for the amount of any out-of-pocket maximums you're responsible for.

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

WHAT ARE MY BENEFITS?

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be medically necessary (please see the "Definitions" section in this booklet) and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan and after any applicable waiting period required under this plan is satisfied.
- It must be furnished by a "provider" (please see the "Definitions" section in this booklet) who's performing services within the scope of his or her license or certification.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions throughout this section and the "What's Not Covered?" section for a complete description of covered services and supplies, limitations and exclusions.

WHAT ARE MY BENEFITS?

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.

WHAT ARE MY COPAYS?

Services subject to a copay when received from a network provider are subject to a calendar year deductible and coinsurance when received from

non-network providers.

Professional Visit Copay

For each office or home visit furnished by a network provider, you pay \$20.

Certain services don't require a copay. However, the Professional Visit Copay may apply if you have a consultation with the provider or receive other services. Separate copays will apply for each separate network provider you receive services from, even if those services are received on the same day.

In addition to office or home visits, this copay also applies to the following services in an office setting:

- Spinal and other manipulations, acupuncture, biofeedback, rehabilitation therapy, neurodevelopmental therapy.

This copay doesn't apply to the following:

- Services listed under the Home and Hospice Care benefit
- Services covered under the Preventive Care benefit
- Office visits solely for services that comply with the federal guidelines for preventive services in the Preventive Care benefit.
- Nutritional therapy

WHAT'S MY CALENDAR YEAR DEDUCTIBLE?

Individual Calendar Year Deductible

For each member, this amount is \$350. This deductible applies to both in-network and non-network providers' services.

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

Please Note: The calendar year deductible accrues toward the out-of-pocket maximum, if any.

Family Deductible

The maximum calendar year deductible for your family is \$700. This deductible applies to both in-network and non-network providers' services.

Fourth Quarter Carryover

Expenses you incur for covered services and supplies in the last 3 months of a calendar year

which are used to satisfy all or part of the calendar year deductible **will also** be used to satisfy all or part of the next year's deductible. If your plan also includes an out-of-pocket maximum, however, the expenses carried over to satisfy the next year's deductible will not be applied to the next year's out-of-pocket maximum.

WHAT'S MY COINSURANCE?

When you see network providers, your coinsurance is 20% of allowable charges.

When you see non-network providers, your coinsurance is 40% of allowable charges.

However, there are a few exceptions to the above coinsurance percentages. Please see the benefits listed below for details:

- The Ambulance Services benefit
- The Emergency Room Services benefit
- The Preventive Care benefit
- The Transplants benefit
- The Diagnostic and Screening Mammography benefit
- The Prescription Drugs benefit
- The Health Management benefit
- The Professional Services benefit
- The Vision Exams benefit
- The Vision Hardware benefit

WHAT'S MY OUT-OF-POCKET MAXIMUM?

Individual Maximum – In-Network

For each member, this amount is \$2,350 per calendar year.

Family Maximum – In-Network

For each family, this amount is \$4,700 per calendar year.

Individual Maximum – Out-of-Network

For each member, this amount is \$4,350 per calendar year.

Family Maximum – Out-of-Network

For each family, this amount is \$8,700 per calendar year.

WHAT'S MY ANNUAL PLAN MAXIMUM?

The maximum amount of benefits available to any one member is \$2,000,000 per calendar year. The annual plan maximum renews on each January 1.

The following benefits don't accrue to your annual plan maximum:

- Benefits described in the "Prescription Drugs" section

- Benefits described in the Vision Hardware benefit.

It's important to note that certain benefits of this plan are also subject to separate lifetime benefit maximums.

MEDICAL SERVICES

Acupuncture Services

You pay a \$20 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If you see a non-network provider, acupuncture benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition.

Benefits are provided for up to 12 visits per member per calendar year.

Ambulance Services

Benefits for the following services are subject to your in-network calendar year deductible and coinsurance.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the member that requires transportation.

Ambulatory Surgical Center Services

The following services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Blood Products and Services

Benefits are provided for blood and blood derivatives, subject to your calendar year deductible and coinsurance.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services. The Chemical Dependency Treatment benefit does not have its own benefit maximum.

Benefits are subject to the same calendar year deductible, coinsurance or copays, if any, that you would pay for inpatient or outpatient treatment for other covered medical conditions. To find the amounts you are responsible for, please see the first few subsections of this "What Are My Benefits?" section.

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

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

Please Note: Medically necessary detoxification is covered under the Emergency Room Services and Hospital Inpatient Care benefits.

The Chemical Dependency Treatment benefit doesn't cover:

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, unless they are medically necessary
- Family and marital counseling, and family and marital psychotherapy as distinct from counseling, except when medically necessary to treat the diagnosed substance use disorder or disorders of a member

Contraceptive Management and Sterilization Services

Contraceptive Management and Sterilization Procedures

Consultations

You pay a \$20 copay for each visit in an office setting when you use a network provider. Please

see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Sterilization Procedures

Outpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Injectable, Implantable and Emergency Contraceptives

When you use a network provider, the services shown below are each subject to a \$20 copay for each visit in an office setting. However, no more than one copay will be charged for all services that require a copay that are done in a single visit.

Services subject to the copay are:

- Injectable contraceptives
- Implantable contraceptives (including hormonal implants)
- Emergency contraception methods (oral or injectable) when furnished by your health care provider

Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If the above contraceptive management or sterilization services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Prescription Contraceptives Dispensed By A Pharmacy

Prescription contraceptives (including emergency contraception) and prescription barrier devices, such as diaphragms and cervical caps, dispensed by a licensed pharmacy are covered on the same basis as any other covered prescription drug. Please see the Prescription Drugs benefit.

This benefit doesn't cover:

- Non-prescription contraceptive drugs, supplies or devices
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Dental Services

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

Care For Injuries

Professional Visits

The professional visit copay applies to dentist visits to examine the damage done by a dental injury and recommend treatment. You pay a \$20 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Dental Treatment

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If the above services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

When services are related to an injury, benefits are provided for the reparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
 - Extensive restoration, veneers, crowns or splints
 - Periodontal disease or other condition that would cause the tooth to be in a weakened

state prior to the injury

Please Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets the plan's extension criteria. We must receive extension requests within 12 months of the injury date.

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Ambulatory Surgical Center Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

If services and supplies are furnished by a non-network ambulatory surgical center or hospital, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Anesthesiologist Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

If anesthesiologist services are provided by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

General anesthesia and related facility services for dental procedures are covered when medically necessary for 1 of 2 reasons:

- The member is under the age of 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center

Please Note: This benefit will not cover the dentist's services unless the services are to treat a dental injury and meet the requirements described above.

Diagnostic Services

Benefits for **preventive diagnostic services** aren't subject to your calendar year deductible and coinsurance, when you use a network provider. Preventive diagnostic services are laboratory and imaging services that meet the guidelines for preventive care stated in the Preventive Care benefit. Please note: Screening tests for prostate cancer will be covered when recommended by your physician, registered nurse, or a physician's assistant.

When you use a network provider, benefits for **non-preventive diagnostic services** are subject to your coinsurance (your calendar year deductible is waived). However, diagnostic surgeries, including scope insertion procedures, such as endoscopies, can only be covered under the Surgical Services benefit.

If you see a non-network provider, benefits for all diagnostic services are subject to your coinsurance (your calendar year deductible is waived). For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Diagnostic imaging and scans (including x-rays and EKGs)
- Screening tests for prostate, colorectal and cervical cancer
- Laboratory services, including routine and preventive
- Pathology tests

In addition to 'What's Not Covered?' this Diagnostic Services benefit doesn't cover:

- Allergy testing. See the Professional Visits and Services benefit for coverage of allergy testing.
- Covered inpatient diagnostic services that are furnished and billed by an inpatient facility. These services are only eligible for coverage under the applicable inpatient facility benefit.
- Outpatient diagnostic services that are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services. Benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.
- Mammography services. Please see the Diagnostic and Screening Mammography benefit.

Preventive Colon Health Screenings

Preventive colon health screenings include routine and preventive colonoscopies, sigmoidoscopies, and

barium enemas. Facility, anesthesia, and professional charges for these colorectal screening tests are covered at 100% of allowable charges, when services are provided by network providers.

If you see a non-network provider, benefits for preventive colon health screenings are subject to your plan year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Please note: Medically necessary colonoscopies are treated as any other surgery (subject to deductible and coinsurance). Also on a preventive colonoscopy if there is a polyp removed the biopsy would be treated as any other X-ray and lab and are subject to your coinsurance.

For coverage criteria on diagnostic services related to a diagnosis of obesity, please see the Obesity Treatment benefit.

Diagnostic and Screening Mammography

Benefits for **preventive** mammography services aren't subject to your plan year deductible or coinsurance when furnished by a network provider.

Benefits for **diagnostic mammography services** are subject to your coinsurance (your plan year deductible is waived), when furnished by a network provider.

Please Note: If you see a non-network provider, benefits for diagnostic and screening mammography are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

The Diagnostic and Screening Mammography benefit covers diagnostic and screening mammography recommended by your physician, advanced registered nurse practitioner or physician's assistant.

Emergency Room Services

Emergency room services are subject to your in-network calendar year deductible and coinsurance.

This benefit is provided for emergency room services, including related services and supplies, such as surgical dressings and drugs, furnished by and used while in the emergency room. Also covered under this benefit are medically necessary detoxification services. This benefit covers outpatient diagnostic services when they are billed by the emergency room and are received in combination with other hospital or emergency room services.

For chemical dependency treatment benefit

information, please see the Chemical Dependency Treatment benefit.

Health Management

These services are provided at 100% of allowable charges. Benefits are only provided when the following services are furnished by network providers or approved providers. To obtain a list of network providers or approved providers, contact our Customer Service department.

Benefits are not subject to a calendar year maximum.

Health Education

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

Nicotine Dependency Programs

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

Home and Hospice Care

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

Benefits are provided, up to the maximums shown below, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

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

Home Health Care

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are provided by network providers.

Please Note: If you see a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit provides up to 130 intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit. Home health care provided as an alternative to inpatient hospitalization is not subject to this limit.

Hospice Care

Benefits for a terminally ill member shall not exceed 6 months of covered hospice care. Benefits may be provided for an additional 6 months of care in cases where the member is facing imminent death or is entering remission. The initial 6-month period starts on the first day of covered hospice care. Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under Home Health Care. You pay the same share of the allowable charge for in-home hospice care as you do for home health care.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.
- **Inpatient hospice care** up to a maximum of 10 days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.

Inpatient hospice care is subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

Prescription drugs and insulin are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If prescription drugs and insulin are furnished and billed by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice.

This benefit doesn't cover:

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

Hospital Inpatient Care

The following services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network hospital, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs,

dressings, equipment and oxygen

- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration
- Medically necessary detoxification services.

For inpatient hospital chemical dependency treatment, except as stated above for medically necessary detoxification services, please see the Chemical Dependency Treatment benefit.

For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

For benefit information on professional diagnostic services done while at the hospital, see the Diagnostic Services benefit.

This benefit doesn't cover:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary.
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition.

Hospital Outpatient Care

Outpatient Surgery Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Other Outpatient Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network outpatient facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit covers operating rooms, procedure rooms, and recovery rooms. Also covered are services and supplies, such as surgical dressings and drugs, furnished by and used while at the hospital. This benefit covers outpatient diagnostic services only when they are billed by the hospital and received in combination with other outpatient hospital services.

Infusion Therapy

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are furnished by a network provider.

Please Note: When infusion services and supplies are furnished by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

This benefit doesn't cover over-the-counter drugs, solutions and nutritional supplements.

Mastectomy and Breast Reconstruction Services

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional and Surgical Services

Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Outpatient Surgical Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Visits

You pay a \$20 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Please Note: If mastectomy or breast reconstruction services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

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

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

Medical Equipment and Supplies

Benefits for the following services are subject to your calendar year deductible and coinsurance when you use a network provider.

If you see a non-network provider, benefits for medical equipment and supplies are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Covered medical equipment, prosthetics and supplies include:

Medical and Respiratory Equipment

Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. The plan may also provide benefits for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is

less costly and serves the same medical purpose, the plan will provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical Supplies, Orthotics (Other Than Foot Orthotics), and Orthopedic Appliances

Covered services include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

Please Note: This benefit does not include medical equipment or supplies provided as part of home health care. See the Home and Hospice Care benefit for coverage information.

For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, please see the Prescription Drugs benefit.

Prosthetics

Benefits for external prosthetic devices (including fitting expenses) as stated below, are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

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

Foot Orthotics and Therapeutic Shoes

Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses up to a combined maximum benefit of \$300 per member each calendar year. Items prescribed for the treatment of diabetes are not subject to this benefit limit.

Medical Vision Hardware

Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

This benefit doesn't cover:

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features

- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Eyeglasses or contact lenses for conditions not listed as a covered medical condition, including routine eye care
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.

Mental Health Care

Benefits for mental health services, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided as stated below. The Mental Health Care benefit does not have its own benefit maximum.

Benefits are subject to the same calendar year deductible, coinsurance or copays, if any, as you would pay for inpatient services and outpatient visits for other covered medical conditions. To find the amounts you are responsible for, please see the first few subsections of this "What Are My Benefits?" section.

Covered mental health services are inpatient care, partial hospitalization and outpatient therapeutic visits to manage or lessen the effects of a psychiatric condition. Also covered under this benefit are outpatient biofeedback services for generalized anxiety disorder when provided by a qualified provider.

"Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Current Procedural Terminology** manual, published by the American Medical Association.

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

Covered services must be furnished by one of the following types of providers:

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

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

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

For coverage criteria on mental health visits related to a diagnosis of obesity, please see the Obesity Treatment benefit.

The Mental Health Care benefit doesn't cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed mental disorder or disorders of a member
- Mental health residential treatment

Neurodevelopmental Therapy

Benefits are provided for the treatment of neurodevelopmental disabilities for members under the age of 7. The following inpatient and outpatient neurodevelopmental therapy services must be medically necessary to restore and improve function, or to maintain function where significant physical deterioration would occur without the therapy. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

Inpatient Care Benefits for inpatient facility and professional care are provided up to 30 days per member each calendar year. Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting.

Inpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for inpatient care are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Outpatient Care Benefits for outpatient care are subject to all of the following provisions:

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

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, up to a maximum benefit of 45 visits per member each calendar year.

Please note: Benefits for massage therapy are limited to 60 minutes per visit.

Outpatient Facility Care

You pay a \$20 copay per visit when you use a network facility.

Outpatient Professional Services

You pay a \$20 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for outpatient care are subject to your

calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

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

This benefit doesn't cover:

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

Newborn Care

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

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

Plan benefits and provisions will apply, subject to the child's own applicable copay, calendar year deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If the newborn is admitted to a non-network medical facility, benefits for inpatient facility services are subject to your calendar year deductible and coinsurance. For an explanation of the amount

you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

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

Professional Care

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

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

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

Inpatient Professional Care

Benefits for these services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Outpatient Professional Visits

You pay a \$20 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If you use a non-network provider, benefits for professional services are subject to your

calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

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

Nutritional Therapy

Benefits for the following services aren't subject to your office visit copay when you use a network provider.

If you see a non-network provider, nutritional therapy benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Obesity Treatment

Non-Surgical Weight Management

Benefits for non-surgical weight management are covered on the same basis as any other covered condition, subject to the applicable benefits, limitations and exclusions.

Non-Surgical Weight Management benefits include, but aren't limited to, coverage of the following outpatient medical services:

- Behavioral health visits
- Nutritional/dietician visits
- Physical therapy visits
- Physician visits
- Related lab and diagnostic services

For specific benefit information, please see the Mental Health Care, Nutritional Therapy, Rehabilitation Therapy and Chronic Pain Care, Professional Visits, Prescription Drug, and Diagnostic Services benefits.

Surgical Treatment of Morbid Obesity

Benefits for surgical treatment of morbid obesity are covered the same as any other covered condition subject to the criteria listed below, applicable benefits, limitations and exclusions.

This benefit will be provided only when covered services are furnished by network providers.

A benefit advisory is highly recommended for members considering this approach to weight loss. For information on obtaining a benefit advisory, please contact our Customer Service department. You'll find the phone number on the back cover of this booklet.

Coverage is available for bariatric procedures listed as medically necessary in Premera Blue Cross medical policy, when conservative measures have proven ineffective. Examples of conservative measures include but aren't limited to covered services under the Non-Surgical Weight Management benefit, diet and exercise programs.

To qualify for the surgical treatment for morbid obesity benefit, the member must meet the following criteria:

- Diagnosed as morbidly obese with a Body Mass Index (BMI) greater than or equal to 40; or
- Overweight with a BMI greater than 35 with severe comorbidities, including but not limited to:
 - Congestive heart failure disease (CHF)
 - Coronary Heart Disease
 - Diabetes
 - Hyperlipidemia
 - Hypertension
 - Sleep Apnea

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

The Obesity Treatment benefit doesn't cover:

- Procedures or treatments that Premera Blue Cross and its affiliates deem are experimental and investigational (please see the "Definitions" section in this booklet)
- Surgical removal of excess abdominal, arm or other skin or liposuction unless medically necessary
- Over-the-counter medications for weight loss
- Liquid diet or fasting programs
- Other food replacement and nutritional supplements
- Membership in diet programs
- Health clubs
- Wiring of the jaw
- Weight management drugs

Obstetrical Care

Benefits for obstetrical care are provided on the same basis as any other condition for all female

members.

The Obstetrical Care benefit includes coverage for voluntary termination of pregnancy.

Facility Care

Inpatient Hospital Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Birthing Center and Short-Stay Hospital Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If you receive inpatient or outpatient care in a non-network medical facility, facility care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit covers inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

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

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

Professional Care

Benefits for the following obstetrical care services are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If you see a non-network provider, the following professional care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus

- Delivery, including cesarean section, in a medical facility, or delivery in the home
- Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

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

Phenylketonuria (PKU) Dietary Formula

Benefits for PKU dietary formula are subject to your calendar year deductible and coinsurance.

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU). This benefit isn't subject to the waiting period for pre-existing conditions, explained in the "What's Not Covered?" section.

Preventive Care

What Are Preventive Services?

Preventive services are now defined as follows:

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

A full list of these preventive services is available on our Web site or by calling Customer Service. The list also provides the guidelines on how often the services should be provided and who should receive them. Not all services recommended or billed by your doctor as part of your routine physical may comply with these guidelines. The list and guidelines are subject to change as required by law and regulation.

Services designated as preventive care when they meet the federal guidelines include periodic exams, routine immunizations described below and laboratory and imaging services that are covered as preventive under the Diagnostic Services benefit and the Diagnostic and Screening Mammography benefits.

Preventive Exams And Immunizations

Preventive exams and immunizations other than seasonal immunizations must be furnished by network providers to be covered. Benefits for preventive exams and immunizations performed on an outpatient basis aren't subject to any deductible, copay, coinsurance or a separate benefit maximum.

Exams The following exam services are covered as long as they fall within the federal guidelines above in this benefit:

- Routine physical exams
- Well-baby and well-child exams
- Physical exams related to school, sports and employment

Immunizations Immunizations other than seasonal immunizations are covered only when furnished by a network provider. Seasonal immunizations, such as flu shots, flu mist, pneumonia immunizations; and adult shingles immunizations, are covered when furnished by any pharmacy or other mass immunizer location.

This benefit doesn't cover:

- Charges that don't meet the federal guidelines for preventive services described at the start of this benefit. This includes services or items provided more often than as stated in the guidelines.
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
- Routine or other dental care
- Routine vision and hearing exams
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member. Please see the plan's non-preventive benefits for available coverage.
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations
- Preventive laboratory and imaging services, screening and diagnostic mammography. Please see the Diagnostic Services benefit and the Diagnostic and Screening Mammography benefit for available coverage.

Professional Visits and Services

Outpatient Professional Exams and Visits

You pay a \$20 copay per visit in a home or office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside of a home or office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If you see a non-network provider, professional benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see "Definitions")
- Diabetic foot care
- Repair of a dependent child's congenital anomaly
- Consultations and treatment for nicotine dependency

For coverage criteria on professional visits related to a diagnosis of obesity, please see the Obesity Treatment benefit.

Therapeutic Injections And Allergy Tests

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If therapeutic injections, allergy injections and allergy testing are furnished by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are available for the following:

- Therapeutic injections, including allergy injections

- Allergy testing

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

For professional diagnostic services benefit information, please see the Diagnostic Services benefit.

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

For benefit information on contraceptive injections or implantable contraceptives, please see the Contraceptive Management and Sterilization Services benefit.

Psychological and Neuropsychological Testing

The following services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If you see a non-network provider, benefits for psychological and neuropsychological testing are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided up to a maximum benefit of 12 hours per member each calendar year for all services combined. Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the Rehabilitation Therapy and Chronic Pain Care benefit.

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

Rehabilitation Therapy and Chronic Pain Care

Rehabilitation Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Please see the Neurodevelopmental Therapy benefit earlier

in this section for coverage of disorders caused by neurological congenital anomalies.

Inpatient Care Benefits for inpatient facility and professional care are available up to 30 days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

Inpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, rehabilitation inpatient care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Outpatient Care Benefits for outpatient care are subject to all of the following provisions:

- You must not be confined in a hospital or other medical facility
- Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, physical, occupational, or speech therapist, chiropractor, massage practitioner or naturopath.

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 45 visits per member each calendar year. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

Please note: Benefits for massage therapy are

limited to 60 minutes per visit.

Outpatient Facility Care

You pay a \$20 copay per visit when you use a network facility.

Outpatient Professional Services

You pay a \$20 copay per visit in an office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When rehabilitation therapy isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, rehabilitation outpatient care benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

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

Chronic Pain Care

These services must also be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits. All benefit maximums apply. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

The Rehabilitation Therapy and Chronic Pain Care benefit doesn't cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary

The plan won't provide the Rehabilitation Therapy and Chronic Pain Care benefit and the Neurodevelopmental Therapy benefit for the same condition. Once a calendar year maximum has

been exhausted under one of these benefits, no further coverage is available.

For coverage criteria on physical therapy visits related to a diagnosis of obesity, please see the Obesity Treatment benefit.

Skilled Nursing Facility Services

Benefits for the following services are subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If you're admitted to a non-network medical facility, benefits for facility services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 90 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility.

This benefit doesn't cover:

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

Spinal and Other Manipulations

You pay a \$20 copay per visit in a home or office setting when you use a network provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

If you see a network provider outside an office setting, benefits for spinal and other manipulations are subject to your calendar year deductible and coinsurance.

Please Note: If you see a non-network provider, benefits for spinal and other manipulations are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition. Benefits are limited to 12 visits

per member per calendar year.

Non-manipulation services (including diagnostic imaging) are covered as any other medical service.

Available benefits for covered massage and physical therapy services are provided under the Rehabilitation Therapy and Chronic Pain Care and Neurodevelopmental Therapy benefits.

Surgical Services

Benefits for the following services are subject to your calendar year deductible and coinsurance when services are provided by a network provider.

Please Note: If you use a non-network provider, benefits for surgical services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit covers surgical services (including injections) that are not named as covered under other benefits, when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office. Also covered under this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts, repair of a dependent child's congenital anomaly, and the transfusion of blood or blood derivatives. Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services as described in the Preventive Care benefit. Please see the Diagnostic Services benefit for coverage of preventive diagnostic services.

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

Temporomandibular Joint (TMJ) Disorders

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Inpatient Professional and Surgical Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network provider.

Outpatient Surgical Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you use a network facility.

Outpatient Professional Visits

You pay a \$20 copay per visit in an office setting when you use a network provider. Please see the

"Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When you see a network provider outside an office setting, benefits are subject to your calendar year deductible and coinsurance.

Other Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance when you see a network provider.

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for temporomandibular joint (TMJ) disorders are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. Treatment of TMJ disorders is not covered under other benefits of this plan.

This benefit includes coverage for inpatient and outpatient facility and professional care, including professional visits, up to a maximum benefit of \$1,000 per member each calendar year. The lifetime maximum for these services is \$5,000 per member.

Medical and dental services and supplies are those that meet all of the following requirements:

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

Transplants

Waiting Period

This plan doesn't provide benefits for an organ, bone marrow or stem cell transplant, including any procedure associated with the transplant (for example, testing, blood typing, chemotherapy, radiation or hospitalization) for the first 6 consecutive

months after your effective date. However, this waiting period may be reduced as explained in the "How Waiting Periods Can Be Shortened Or Waived" section below in this booklet.

Please Note: Transplant-related services are also subject to the waiting period for pre-existing conditions (please see the "What's Not Covered?" section in this booklet for more information about this waiting period).

Transplant benefits do not have a separate benefit maximum. Benefits for covered transplants are subject to the plan's overall lifetime benefit maximum as described under "Does My Plan Have A Lifetime Maximum." Donor charges and transplant-related transportation and lodging do have separate benefit maximums as described below.

Covered Transplants

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

Inpatient Facility Services

Benefits for services in a network facility or an approved transplant center are subject to your in-network calendar year deductible and coinsurance.

Inpatient Professional and Surgical Services

Benefits for a network provider or an approved transplant provider are subject to your in-network calendar year deductible and coinsurance.

Outpatient Surgical Facility Services

Benefits for a network facility or an approved transplant center are subject to your in-network calendar year deductible and coinsurance.

Outpatient Professional Visits

You pay a \$20 copay per visit in an office setting to a network provider or an approved transplant provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When a professional visit isn't provided in an office setting, benefits are subject to your in-network calendar year deductible and coinsurance.

Other Outpatient Professional Services

Benefits for a network provider or an approved transplant provider are subject to your in-network calendar year deductible and coinsurance.

Transport and Lodging

The transport and lodging benefits are subject to your in-network calendar year deductible, but aren't subject to your in-network coinsurance. Benefits are provided up to the benefit limit of \$7,500 per transplant.

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

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

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

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

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

- You've satisfied your waiting period.
- Your medical condition must meet the plan's written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An "approved transplant center" is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically

possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

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

Recipient Costs

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

Donor Costs

Procurement expenses are limited to \$75,000 per transplant. All covered donor costs accrue to the donor costs maximum, no matter when the donor receives them. Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation and Lodging Expenses

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

- The transplant recipient must reside more than 50 miles from the approved transplant center unless medically necessary treatment protocols require the member to remain closer to the transplant center
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided up to a maximum of \$125 per day
- When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided up to a maximum of \$80 per day
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companions are limited to \$7,500 per transplant

This benefit doesn't cover:

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

VISION EXAMS

You pay a \$20 copay per visit when you use a network provider. If vision testing is done during the same visit as the routine vision exam, you will pay only one copay.

When you use a non-network provider, your share of the allowable charge is the same as if the provider were a network provider.

This benefit provides for one routine vision exam per member each calendar year. Covered routine exam services include:

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

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

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

VISION HARDWARE

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

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

Benefits for the following vision hardware and related services are provided at 100% of allowable charges, up to a maximum benefit of \$150 per member per calendar year.

What's Covered:

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Vision hardware benefits are based on the "allowable charge" (please see the "Definitions" section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

Please Note: Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don't apply to vision hardware benefits.

The Vision Hardware benefit doesn't cover:

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

PRESCRIPTION DRUGS

The 3-tier Prescription Drugs benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered under this benefit are injectable supplies. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of-pocket expense exceed the cost of the drug or supply.

The Prescription Drugs benefit requires you to pay either a copay or coinsurance for each separate new prescription or refill you get from participating pharmacies. The copay amounts and/or coinsurance percentages are shown below. A "copay" is a fixed up-front dollar amount that you're required to pay to the retail pharmacy or the participating mail-order pharmacy for each prescription drug purchase. "Coinsurance" is the percentage of the allowable charge that you're required to pay to the pharmacy for each prescription drug purchase.

See "Retail Pharmacy Benefit" later in this benefit for the additional amounts you would pay if you went to a non-participating retail pharmacy.

Please Note: Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don't apply to this benefit. Copays and coinsurance required under this benefit don't apply to other benefits of this plan.

Retail Pharmacy Prescriptions

Generic Drugs.....	\$10 copay
Preferred Brand	\$20 copay
Name Drugs	
Non-Preferred Brand	\$40 copay
Name Drugs	

Dispensing Limit

Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

Please note: Dispensing of up to a 90-day supply is allowed and you would be charged an **additional** copay for each 30-day supply up to the 90-day limit, or the cost of the drug if that cost doesn't exceed the cost of the copay.

How To Use The Retail Pharmacy Benefit

- **Participating Retail Pharmacies** After you've paid any required cost-share, the plan will pay the participating pharmacy directly.

To avoid paying the retail cost for a prescription drug that's reimbursable at a lower allowable charge rate, be sure to present your identification card to the pharmacist for all prescription drug purchases.

- **Non-Participating Retail Pharmacies** You pay the full price for the drugs and submit a claim for reimbursement. Please see the "How Do I File A Claim?" section in this booklet for more information.

After you've paid any required cost-share, you pay 40% of the allowable charge for the prescription or refill and the difference between the pharmacy's billed charge and the allowable charge. This benefit applies to all prescriptions filled by a non-participating pharmacy, including those filled via mail or other home delivery.

If you need a list of participating pharmacies, please call us (see the back cover of this booklet). You can also call the toll-free Pharmacy Locator Line; this number is located on the back of your Premera Blue Cross ID card.

Mail-Order Pharmacy Program

Generic Drugs.....	\$20 copay
Preferred Brand	\$40 copay
Name Drugs	
Non-Preferred Brand	\$80 copay
Name Drugs	

Dispensing Limit

Benefits are provided up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of a greater than 90-day supply is permitted when the drug maker's packaging doesn't allow for a lesser amount. If any prescriptions require a copay, you would pay only 1 mail-order copay for each prescription when the drug maker's packaging exceeds the 90-day supply.

How To Use The Mail-Order Pharmacy Program

You can often save time and money by filling your prescriptions through the mail-order pharmacy program. After you've paid any required cost-share, the plan will pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by our participating mail-order pharmacy.

Ask your physician to prescribe needed medications for up to the maximum dispensing limit stated earlier in this benefit, plus refills. If you're presently taking

medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a refill prescription to the mail-order pharmacy. Please see the "How Do I File A Claim?" section in this booklet for more information on submitting claims.

To obtain additional details about the mail-order pharmacy program, you may call our Customer Service department. You may also call the Pharmacy Benefit Administrator's Customer Service department or visit their Web site. You'll find the phone numbers and the Web address on the back cover of this booklet.

What's Covered

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

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of "prescription drug" (please see the "Definitions" section in this booklet).
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescription drugs dispensed by a licensed pharmacy located in Canada that have U.S. FDA-approval, when those drugs are determined to be medically appropriate by the Claims Administrator.
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Prescription drugs for the treatment of nicotine dependency.
- Your normal cost-share for drugs received from a participating pharmacy is waived for certain prescription nicotine dependency drugs that meet the guidelines for preventive services described in the Preventive Care benefit.
- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps)

Injectable Supplies

When insulin needles and syringes are purchased along with insulin, only the cost-share for the insulin will apply.

When insulin needles and syringes are purchased separately, the Preferred Brand Name Drug cost-share will apply for each item purchased.

The Preferred Brand Name Drug cost-share will apply to purchases for alcohol swabs, test strips, testing agents and lancets. If any prescriptions require a copay, a separate copay would apply to each item purchased

Exclusions

This benefit doesn't cover:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but aren't limited to non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility. The exceptions are for growth hormones or drugs provided as part of the plan's Specialty Pharmacy provision (see question 5 in "Questions And Answers About Your Pharmacy Benefits," below), which are payable under this benefit, regardless of where they are administered.
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon, and growth hormones.) Please see the Infusion Therapy benefit.
- Drugs to treat sexual dysfunction
- Weight management drugs
- Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit). Please see the Medical Equipment and Supplies benefit for

available coverage.

- Immunization agents and vaccines, including the professional services to administer the medication. Please see the Preventive Care benefit for available coverage.
- Drugs to treat infertility, including fertility enhancement medications

Prior Authorization Program

To promote appropriate medication use, drugs may be subject to medical necessity review. For certain drugs, this review must occur before the drug is dispensed to you. As part of this pre-dispensing review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent medication. If you choose to purchase the medication before the pre-dispensing review has been completed, you will pay the full price for the drugs. If the review verifies the medicine use is medically necessary, then you may submit a claim for reimbursement. Please see the "How Do I File A Claim?" section in this booklet for more information.

In making these determinations, we take into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.

Contact Customer Service for details on which drugs are included in the Prior Authorization Program, or see the Pharmacy section on our Web site.

You can appeal any decision you disagree with. Please see the "Your Ideas, Questions, Complaints And Appeals" section in this booklet, or call our Customer Service department.

Prescription Drug Volume Discount Program

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

Questions and Answers About Your Pharmacy Benefits

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

The plan's prescription drug benefit makes use of our pharmacy drug list. (This is sometimes referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the list.

This plan encourages the use of appropriate "generic drugs" (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. You may request a brand name drug instead of a generic, but if a generic equivalent is available and substitution of the generic drug for the brand-name drug is allowed by the prescriber, you'll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name cost-share. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

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

It's important to note that this plan provides benefits for non-preferred brand name drugs, but at a higher cost to you.

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

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

Certain drugs are subject to pre-dispensing medical necessity review. As part of this review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent medication. Please see "Prior Authorization Program" described above for additional detail.

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

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

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

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

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

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

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

The amount you pay for covered drugs dispensed by a retail pharmacy or through the mail-order pharmacy benefit is described above.

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

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

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

card.

Specialty Pharmacy Program "Specialty drugs" are drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis or growth disorders (excluding idiopathic short stature without growth hormone deficiency).

The plan makes use of our contracted specific specialty pharmacies that specialize in the delivery and clinical management of specialty drugs. You and your health care provider must work with our participating specialty pharmacies to arrange ordering and delivery of these drugs.

Please note: This plan will only cover specialty drugs that are dispensed by our participating specialty pharmacies. Benefits for specialty drugs dispensed through the Specialty Pharmacy program are limited to a 30-day supply, and are subject to the cost sharing specified above under "Retail Pharmacy" benefit. Contact Customer Service for details on which drugs are included in the Specialty Pharmacy Program, or visit our Web site, which is shown on the back cover of this booklet.

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

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the mail-order pharmacy benefit are described in the "Dispensing Limit" provision above.

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

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

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

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

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

BLUECARD® PROGRAM AND OTHER INTER-PLAN ARRANGEMENTS

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

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

Network Providers

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

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

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

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

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

the same types of transactions as an estimated price.

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

Clark County Providers

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

Non-Network Providers

When covered services are provided outside Washington and Alaska or in Clark County, Washington by non-network providers, the allowable charge will generally be based on the Host Blue's allowable charge for non-network providers unless a different allowable charge is required by applicable state law. You are responsible for the difference between the amount that the non-network provider bills and this plan's payment for the covered services.

Exceptions Required By Law

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

BlueCard Worldwide®

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

outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you'll typically have to submit the claims yourself to obtain reimbursement for these services.

Further Questions?

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

CARE MANAGEMENT

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

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment and to help us identify admissions that might benefit from case management.

CASE MANAGEMENT

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of this plan's benefits. The decision to provide benefits for these alternatives is within the plan's sole discretion. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

Case Management is subject to the terms set forth in the signed written agreements. Your plan benefits may be utilized as specified in the signed agreements, but the agreements are not to be construed as a waiver of the right to administer the plan in strict accordance with its terms in other situations. All parties have the right to re-evaluate or terminate the Case Management agreement at any time, at their sole discretion. Case Management termination must be provided in writing to all parties. Your remaining benefits under this plan would be available to you at that time.

DISEASE MANAGEMENT

Our Disease Management programs are designed to improve health outcomes for members with certain chronic diseases. These programs seek to identify

individuals who may benefit from such programs and to achieve the best possible therapeutic outcomes based on an assessment of the patient needs, ongoing monitoring of care and consultation with your providers. Participation in Disease Management programs is voluntary. To learn more about the availability of Disease Management, contact our Customer Service team at the phone number shown on the back cover of this booklet.

WHAT'S NOT COVERED?

This section of your booklet explains circumstances in which all the benefits of this plan are either limited or no benefits are provided. Benefits can also be affected by our "Care Management" provisions and your eligibility. In addition, some benefits have their own specific limitations.

WAITING PERIOD FOR PRE-EXISTING CONDITIONS

A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in the 3 months before your "enrollment date" (please see the "Definitions" section in this booklet).

This plan has a waiting period for pre-existing conditions in members who are 19 or older. The waiting period is 3 months from your enrollment date. Except as noted in "How Waiting Periods Can Be Shortened Or Waived" below, benefits won't be provided for pre-existing conditions until:

- After your coverage becomes effective; and
- Your 3-month waiting period for pre-existing conditions has been met. This waiting period may be reduced as explained in "How Waiting Periods Can Be Shortened Or Waived" below.

WAITING PERIOD FOR TRANSPLANTS

Organ, bone marrow and stem cell transplants are subject to a benefit-specific 6-month waiting period. Except as noted in "How Waiting Periods Can Be Shortened Or Waived" below, benefits won't be provided for transplant-related services for the first six months after your effective date.

HOW WAITING PERIODS CAN BE SHORTENED OR WAIVED

This plan's waiting periods for pre-existing conditions and transplants may be reduced by periods of "creditable" coverage you've accrued under other health care plans prior to your "enrollment date" (see "Definitions") for this plan. Most medical health care coverage is considered creditable (see list below).

You'll receive credit for prior creditable coverage that occurred without a break in coverage of more than 3 months. Coverage you may have had prior to a

break exceeding 3 months will not be credited toward your waiting periods. Eligibility waiting periods (see "Definitions") won't be considered creditable coverage or a break in coverage.

Your prior employer or health insurance carrier will provide you with a certificate of health coverage that includes information about your prior health coverage. If you haven't received a certificate, or have misplaced it, you have the right to request one from a prior employer or health carrier within 24 months of the date your coverage under that plan terminated. If you can't get a certificate, please call Customer Service, because other kinds of proof that you had the coverage are also acceptable.

"Creditable" coverage shall mean coverage under one or more of the following types of health care coverage:

- Group health coverage (including self-funded plans and COBRA)
- Individual health coverage
- Part A or B of Medicare
- Medicaid
- Military health coverage
- Indian Health Service or tribal coverage
- State high risk pool
- Federal or any public health care plan, including state children's health care plans
- Peace Corps Plan
- Government health coverage provided for citizens or residents of a foreign country
- Any other health insurance coverage

"Creditable" coverage doesn't include coverage under a limited policy such as an accident only coverage; disability income insurance; workers' compensation; limited scope dental or vision plans; liability insurance; automobile medical insurance; specified disease coverage; Medicare supplemental policy; or long-term care policy.

The waiting periods for transplants and pre-existing conditions **don't apply** to:

- Pregnancy
- Coverage for PKU dietary formula for members with phenylketonuria.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, the plan won't provide benefits for the following:

Benefits From Other Sources

Benefits aren't available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault

- Personal injury protection (PIP) coverage
- Boat coverage
- Commercial liability coverage
- Homeowner policy
- School or athletic policy
- Other types of liability insurance
- Worker's Compensation or similar coverage
- Any excess insurance coverage

Benefits That Have Been Exhausted

Amounts that exceed the allowable charge or maximum benefit for a covered service.

Biofeedback Services

- Biofeedback for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback and neurofeedback services

Caffeine Or Nicotine Dependency

Treatment of caffeine dependency; treatment of nicotine dependency except as stated under the Health Management, Professional Visits and Services and Prescription Drugs benefits.

Charges For Records Or Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review.

Chemical Dependency Coverage Exceptions

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous

Cosmetic Services

Services and supplies (including drugs) rendered for cosmetic purposes and plastic surgery, whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance or shape of a body structure, including any direct or indirect complications and aftereffects thereof.

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an injury, providing such repair is started within 12 months of the date of the injury
- Repair of a dependent child's congenital anomaly
- Reconstructive breast surgery in connection with a mastectomy as specified under the Mastectomy and Breast Reconstruction Services benefit
- Correction of functional disorders upon our review and approval

Counseling, Educational Or Training Services

- Counseling, education or training services, except as stated under the Chemical Dependency Treatment, Health Management, Nutritional Therapy, Professional Visits and Services and Mental Health Care benefits or for services that meet the standards for preventive services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling; and family and marital psychotherapy, except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of a member.
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities in children under the age of 7 as stated under the Neurodevelopmental Therapy benefit.
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy

Court-Ordered Services

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except as deemed medically necessary by us.

Custodial Care

Custodial care, except when provided for hospice care (please see the Home and Hospice Care benefit).

Dental Care

Dental services or supplies, except as specified under Dental Services (please see the "Medical Services" section under "What Are My Benefits?").

Drugs And Food Supplements

Over-the-counter drugs, solutions, supplies, food and nutritional supplements; over-the-counter contraceptive drugs, supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that don't require a prescription, except as required by law.

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental Or Investigational Services

Any service or supply that Premera Blue Cross determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of "experimental/investigational services" (please see the "Definitions" section in this booklet).

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the "Your Ideas, Questions, Complaints And Appeals" section in this booklet for an explanation of the appeals process.

Please Note: This exclusion does not apply to certain experimental or investigational services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the "Definitions" section in this booklet.

Family Members Or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent or child.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit.

Gender Transformations

Treatment or surgery to change gender, including any direct or indirect complications and after effects thereof.

Governmental Medical Facilities

Services and supplies furnished by a governmental medical facility, except when:

- Your request for a benefit level exception for non-emergent care to the facility is approved (please see the "Benefit Level Exceptions For Non-Emergent Care" provision in this booklet)
- You're receiving care for a "medical emergency" (please see the "Definitions" section in this booklet)
- The plan must provide available benefits for covered services as required by law or regulation

Hair Loss

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

Hearing Exams And Testing

Routine hearing exams and testing.

Hearing Hardware

Hearing aids and devices used to improve hearing sharpness.

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Specialty Pharmacy Program (please see the Prescription Drugs benefit) and are not covered to treat idiopathic short stature without growth hormone deficiency.

Infertility And Sterilization Reversal

- Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs
- Any assisted fertilization techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof
- Reversal of surgical sterilization, including any direct or indirect complications thereof

Medical Equipment And Supplies

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Prosthetics, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit.
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications, except as specified in the Prescription Drugs benefit.

Military And War-Related Conditions, Including Illegal Acts

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto. However, this exclusion does not apply to U.S. military personnel (active or retired) or their dependents enrolled in the

TRICARE program. The benefits of this plan will be provided on a primary basis to TRICARE beneficiaries consistent with federal law.

- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

No Charge Or You Don't Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, except as required by law in the case of federally qualified health center services

Not Covered

- Services or supplies ordered when this plan isn't in effect, or when the person isn't covered under this plan, except as stated under specific benefits and under "Extended Benefits"
- Services or supplies provided to someone other than the ill or injured member, other than outpatient health education services covered under the Health Education portion of the Health Management benefit
- Services and supplies that aren't listed as covered under this plan
- Services and supplies directly related to any condition, or related to any other service or supply that isn't covered under this plan
- Members and this plan are not responsible for payment of services provided by network providers for "serious adverse events," "never events" and resulting follow-up care. "Serious adverse events" and "never events" are medical errors that are specific to a nationally published list. They are identified by specific diagnosis codes, procedure codes and specific present-on-admission indicator codes. A "serious adverse event" means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge. Network providers may not bill members for these services and members are held harmless.

Not In The Written Plan Of Care

Services, supplies or providers not in the written plan of care or treatment plan, or not named as covered in the Home and Hospice Benefit, Neurodevelopmental Therapy and Rehabilitation Therapy and Chronic Pain Care benefits.

Not Medically Necessary

- Services or supplies that aren't medically necessary even if they're court-ordered. This also

includes places of service, such as inpatient hospital care.

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition

On-Line Consultations

Electronic, on-line or internet medical consultations or evaluations.

Orthodontia Services

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

Orthognathic Surgery (Jaw Augmentation Or Reduction)

Procedures to lengthen or shorten the jaw (orthognathic or maxillofacial surgery), regardless of the origin of the condition that makes the procedure necessary. The only exception to this exclusion is for repair of a dependent child's congenital anomaly.

Outside The Scope Of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received.

Personal Comfort Or Convenience Items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home and Hospice Care benefit); and transportation services
- Dietary assistance, such as "Meals on Wheels"

Private Duty Nursing Services

Private duty nursing.

Rehabilitation Services

Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery

that made the rehabilitation necessary.

Routine Or Preventive Care

- Routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof, except as stated under the Professional Visits and Services benefit; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. This includes foot-support supplies, devices and shoes, except as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability
- Charges for services or items that don't meet the federal guidelines for preventive services described in the Preventive Care benefit, except as required by law. This includes services or items provided more often than stated in the guidelines.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

Skilled Nursing Facility Coverage Exceptions

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency

Transplant Coverage Exceptions

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under the Transplants benefit
- Services or supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (please see the "Definitions" section in this booklet)

Vision Therapy

Vision therapy, eye exercise, or any sort of training

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

Work-Related Conditions

- Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
 - Occupational coverage required of, or voluntarily obtained by, the employer
 - State or federal workers' compensation acts
 - Any legislative act providing compensation for work-related illness or injury

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

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

You also may be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a "coordination of benefits" feature to handle such situations. We'll coordinate the benefits of this plan with those of your other plans to make certain that, in each calendar year, the total payments from all medical plans aren't more than the total allowable medical expenses and the total payments from all dental plans aren't more than the total allowable dental expenses.

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

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

Definitions Applicable To Coordination Of Benefits

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

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

policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations

- Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans
- Government programs that provide benefits for their own civilian employees or their dependents

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

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." This means they reduce their payment amounts so that the total benefits from all medical plans aren't more than the allowable medical expenses and the total benefits from all dental plans aren't more than the total allowable dental expenses. We will coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

Primary And Secondary Rules

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

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

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

Non-Dependent Or Dependent The plan that doesn't cover you as a dependent is primary to a

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

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

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

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

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

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

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

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

Any amount by which a secondary plan's benefits have been reduced in accord with this section shall be used by the secondary plan to pay your allowable medical expenses or allowable dental expenses not otherwise paid, and such reduced amount shall be charged against the applicable plan's benefit limit (medical or dental). However, you must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for allowable medical expenses or allowable dental expenses based on all claims that were submitted up to that time during the claim determination period.

Right Of Recovery/Facility Of Payment

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

SUBROGATION AND REIMBURSEMENT

If the plan makes claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, the plan is entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or the plan. This party includes a UIM carrier because it stands in the shoes of a third party tort feisor and because the plan excludes coverage for such benefits.

Definitions The following terms have specific meanings in this section:

- **Subrogation** means we may collect, on behalf of

the plan, directly from third parties to the extent the plan has paid on your behalf for illnesses or injury caused by the third party.

- **Reimbursement** means that you are obligated to repay any monies advanced by the plan from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that the plan has to the monies advanced under your plan. Because the plan has paid for your illness or injuries, the plan is entitled to recover those expenses.

The plan is entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits the plan paid for the condition, whether or not you have been made whole prior to the plan's recovery. The plan's right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. This right allows the plan to pursue any claim against any third party or insurer, whether or not you choose to pursue that claim. The plan's rights and priority are limited to the extent the plan has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights.

The plan's first priority right of reimbursement will not be reduced due to a member's own negligence; or due to a member not being made whole; or due to attorney's fees and costs.

In recovering benefits provided on behalf of the plan, we may at the Group's election hire an attorney or have the plan be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by the plan or the Group or on their behalf. If you retain an attorney or other agent to represent you in the matter, you must require that legal representative to reimburse the plan directly from the settlement or recovery. Before accepting any settlement on your claim against a third party, you or your legal representative must notify us in writing of any terms or conditions offered in a settlement, and you or your legal representative must notify the third party of the plan's interest in the settlement established by this provision. You also must cooperate with us in recovering amounts paid by the plan on your behalf. If you or your legal representative fail to cooperate fully with us in the recovery of benefits the plan has paid as described above, you are responsible for reimbursing the plan for such benefits.

You or your legal representative must, within 14 business days of receiving a request from the plan, provide all information and sign and return all documents necessary to exercise the plan's right under this provision.

To the extent that you recover from any available third party source, you agree to hold any recovered fund in trust or in a segregated account until the plan's subrogation and reimbursement rights are fully determined.

Agreement To Arbitrate Any disputes that arise as part of this provision will be resolved by arbitration. Both you and the plan will be bound by the decision of the arbitration proceedings.

Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in King County, Washington.

This agreement to arbitrate will begin on the effective date of the plan, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

WHO IS ELIGIBLE FOR COVERAGE?

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

SUBSCRIBER ELIGIBILITY

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

- Be a regular and active employee, owner, partner, retiree, or corporate officer of the Group who is paid on a regular basis through the Group's payroll system, and reported by the Group for Social Security purposes.
- Regularly work a minimum of 17.5 hours per week, unless retired.

Employees Performing Employment Services In Hawaii

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the Group is located) be administered according to Hawaii law. If the Group

is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the Group in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the Group there, he or she will no longer be eligible for coverage.

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated. ("Lawful spouse" means a legal union of two persons that was validly formed in any jurisdiction.)
- All rights and benefits afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage", the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible dependent child who is under 26 years of age.
- An eligible child is one of the following:
 - A natural offspring of either or both the subscriber or spouse
 - A legally adopted child of either or both the subscriber or spouse
 - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
 - A legally placed ward of the subscriber or spouse. There must be a court order signed by a judge, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

Foster children aren't eligible for coverage.

WHEN DOES COVERAGE BEGIN? ENROLLMENT

Enrollment is timely when we receive the completed enrollment application and required subscription charges within 60 days of the date the employee becomes an "eligible employee" as defined in the "Who Is Eligible For Coverage?" section. When enrollment is timely, coverage for the employee and

enrolled dependents will become effective on the first of the month that coincides with or next follows the **latest** of the applicable dates below.

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

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

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

Dependents Acquired Through Marriage After The Subscriber's Effective Date

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

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

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

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

provision later in this section.

Adoptive Children Acquired On Or After The Subscriber's Effective Date

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

Children Acquired Through Legal Guardianship

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

Children Covered Under Medical Child Support Orders

When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid or the state child support enforcement agency. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

SPECIAL ENROLLMENT

The plan allows employees and dependents to enroll outside the plan's annual open enrollment period, if any, only in the cases listed below. In order to be

enrolled, the applicant may be required to give us proof of special enrollment rights. If a completed enrollment application is not received within the time limits stated below, further chances to enroll, if any, depend on the normal rules of the plan that govern late enrollment.

Coverage will start on the first of the month following the date we receive the application for coverage. In order to be enrolled, the applicant may be required to give us proof of special enrollment rights.

Involuntary Loss of Other Coverage

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

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

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

We must receive the completed enrollment application and any required subscription charges from the Group within 30 days of the date such other coverage ended.

Subscriber And Dependent Special Enrollment

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under "Enrollment" in the case of marriage,

birth or adoption. The eligible employee may also choose to enroll without enrolling any eligible dependents.

State Medical Assistance and Children's Health Insurance Program

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

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

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

OPEN ENROLLMENT

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

CHANGES IN COVERAGE

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

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

PLAN TRANSFERS

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

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

- Benefit maximums
- Lifetime maximums
- Waiting period for pre-existing conditions
- Transplant waiting period
- Annual plan maximum
- Out-of-pocket maximum
- Calendar year deductible.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when:
 - The next required monthly charge for coverage isn't paid when due or within the grace period
 - The subscriber dies or is otherwise no longer eligible as a subscriber
 - The Group contract is terminated
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she cannot meet the requirements for dependent coverage shown under the "Who Is Eligible For Coverage?" section.

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

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 and Dependent immediately when they return to the United States.

The Member must return to the United States within **365** days 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.

PLAN TERMINATION

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

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

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

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

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

LABOR DISPUTE

A subscriber may pay subscription charges through the Group to keep coverage in effect for up to 6

months in the event of suspension of compensation due to a lockout, strike, or other labor dispute.

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

COBRA

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

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

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

Qualifying Events and Length of Coverage

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

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

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
 - **The subscriber's work hours are reduced.**
 - **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

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

- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the

first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.

- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
 - **The subscriber dies.**
 - **The subscriber and spouse legally separate or divorce.**
 - **The subscriber becomes entitled to Medicare.**
 - **A child loses eligibility for dependent coverage.**

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

Conditions of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage. Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date the qualified member would lose coverage as the result of one of these events; or

3) date of the disability determination. **Please note: Determinations that a qualified member is disabled must be given to the Group before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice.** Please include a copy of the determination with your notice to the Group.

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

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

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

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

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

You Must Enroll And Pay On Time

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

you believe this may apply to you.

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

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

Adding Family Members

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

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

- The applicable continuation period expires.
- The next monthly payment isn't paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see "Qualifying Events and Lengths Of Coverage" in this section), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more

than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.

- You become covered under another group health care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group health care coverage to any employee.

However, even if one of the events above hasn't occurred, COBRA coverage **under this plan** will end on the date that the contract between the Group and us is terminated.

If You Have Questions

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

CONTINUATION UNDER USERRA

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

Contact your employer for information on USERRA rights and requirements. You may also contact the

U.S. Department of Labor at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

MEDICARE SUPPLEMENT COVERAGE

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

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

Step 1

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

Step 2

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

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

Step 3

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

of Medicare Benefits."

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

Prescription Drug Claims

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

Participating Pharmacies

For retail pharmacy purchases, you don't have to send us a claim. Just show your Premera Blue Cross ID card to the pharmacist, who will bill us directly. If you don't show your ID card, you'll have to pay the full cost of the prescription and submit the claim yourself.

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

Non-Participating Pharmacies

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

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

Timely Filing

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

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

The plan won't provide benefits for claims we receive after the later of these 2 dates, nor will the

plan provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

Special Notice About Claims Procedure

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

If your claim was denied, in whole or in part, our written notice will include:

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

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

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

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

YOUR IDEAS, QUESTIONS, COMPLAINTS AND APPEALS

Please call Customer Service when you have questions about a benefit or coverage decision or the quality or availability of a health care service. Customer Service can quickly and informally correct errors and clarify benefits. There may be times when Customer Service will ask you to submit your complaint for review through the formal appeals process outlined below.

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

If you need an interpreter to help with oral translation services, please call us. Customer Service will be able to guide you through the service.

WHEN YOU DISAGREE WITH A PAYMENT OR BENEFIT DECISION

If payment or benefits were denied in whole or in part, and you disagree with that decision, you have the right to ask the plan to review that adverse benefit determination through a formal, internal appeals process.

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

What is an adverse benefit determination?

An adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for services, based on:

- An individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- A pre-existing condition exclusion or other limitation on otherwise covered benefits;
- A utilization review determination; or
- A determination that a service is experimental, investigational, or not medically necessary or appropriate.

WHEN YOU HAVE AN APPEAL

Your plan includes two levels of internal appeals.

Your Level I internal appeal will be reviewed by individuals who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be provided by a health care provider. They will review all of the information relevant to your appeal and will provide a written determination. If you are not satisfied with the decision, you may request a Level II appeal.

Your Level II internal appeal will be reviewed by a panel of individuals who were not involved in any previous decisions. If your appeal involves medical judgment, a health care provider will be included in the panel. You may participate in the Level II panel meeting in person or by phone to present evidence and testimony. Please contact us for additional information about this process.

Once the Level II review is complete, you will receive a written determination. If you are not satisfied with

the final internal appeal decision, you may be eligible to request an external review, as described below.

Who may file an internal appeal?

You or your authorized representative, someone you have named to act on your behalf, may file an appeal. To appoint an authorized representative, you must sign an authorization form and mail or fax the signed form to the address or phone number listed below. This release provides us with the authorization for this person to appeal on your behalf and allows our release of information, if any, to them.

Please call us for an authorization form. You can also obtain a copy of this form on our Web site at www.premera.com.

How do I file an internal appeal?

You or your authorized representative may file an appeal by calling Customer Service or by writing to us at the address listed below. We must receive your appeal request as follows:

- For a Level I internal appeal, within 180 calendar days of the date you were notified of the adverse benefit determination.
- For a Level II internal appeal, within 60 calendar days of the date you were notified of the Level I determination. If you are hospitalized or traveling, or for other reasonable cause beyond your control, we will extend this timeline up to 180 calendar days to allow you to obtain additional medical documentation, physician consultations or opinions.

You may submit your written appeal request to:

Premera Blue Cross
Attn: Appeals Department, MS 123
P.O. Box 91102
Seattle, WA 98111-9202

Or, you may fax your request to:

Appeals Department
(425) 918-5592

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on the back cover of this benefit booklet.

How will I know that you received my request for an appeal?

A written notice acknowledging receipt of your appeal request will be sent to you.

What if my situation is clinically urgent?

If your provider believes that your situation is clinically urgent under law, your appeal will be

conducted on an expedited basis. A clinically urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. You may request an expedited internal appeal by calling Customer Service at the number listed on the back of this booklet.

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

Can I provide additional information for my appeal?

You may supply additional information to support your appeal at the time you file an appeal or at a later date by mailing or faxing to the address and fax number listed above. Please provide this information as soon as possible.

Can I request copies of information relevant to my appeal?

You can request copies of information relevant to the adverse benefit determination. This information will be provided as well as any new or additional information that was considered, relied upon or generated in connection to your appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond before a decision is made.

What happens next?

The adverse benefit determination will be reviewed and you will receive a written decision as stated below:

- Expedited appeals: as soon as possible, but no later than 72 hours after we received your request. You will be notified of the decision by phone, fax or email and will be followed by a written decision.
- Adverse benefit determinations made prior to you receiving services: 15 days of the date we received your request.
- All other appeals: within 30 days of the date we received your request.

If the adverse benefit determination is upheld, you will be provided information about your right to an a Level II internal appeal or your right to external review at the end of the internal appeals process.

Appeals Regarding Ongoing Care

If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, we will suspend the plan's denial of benefits during the internal appeal period. The

plan's provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse the plan's denial. If the decision is upheld, you must repay all amounts the plan paid for such services. You will also be responsible for any difference between the allowable charge and the provider's billed charge.

WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?

If you are not satisfied with the final internal adverse benefit determination based on medical necessity, experimental or investigative, health care setting, level of care or effectiveness of a covered benefit, you may have the right to have the decision reviewed by an Independent Review Organization (IRO).

An IRO is an independent organization of medical reviewers who are qualified to review medical and other relevant information. There is no cost to you for an external review.

You will be provided with an external review request form at the end of the internal appeal process notifying you of your rights to an external review. Your written request for an external review must be received no later than 4 months after the date you received the final internal adverse benefit determination. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to your request.

You can request an expedited external review when your provider believes that your situation is clinically urgent under law. Please call Customer Service at the number listed on the back cover of this benefit booklet to request an expedited external review.

We will notify the IRO of your request for an external review. The IRO will let you, your authorized representative and/or your attending physician know where additional information may be submitted directly to the IRO and when the information must be provided.

How will I know when the IRO has completed the external review?

Once the external review is completed, the IRO will notify you and us in writing of their decision within 45 days.

If you have requested an expedited external review, the IRO will notify you and us of their decision immediately by phone, e-mail or fax after they make their decision, and will follow up with a written decision by mail.

What happens next?

The plan is bound by the decision made by the IRO. If the IRO overturned the final internal adverse benefit determination, their decision will be

implemented.

If the IRO upheld the final internal adverse benefit determination, there is no further review available under this Plan's internal appeals or external review process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Evidence Of Medical Necessity

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

Intentionally False Or Misleading Statements

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

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

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

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

Member Cooperation

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

Notice Of Information Use And Disclosure

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

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

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

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

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

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

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

Notice Of Other Coverage

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

- Any legal action or claim against another party for a condition or injury for which the plan provides benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
 - Personal injury protection (PIP)
 - Underinsured motorist coverage
 - Uninsured motorist coverage

- Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

Notices

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

Right Of Recovery

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

Right To And Payment Of Benefits

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

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

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

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

Venue

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

- Within 3 years of the date the rights or benefits claimed under this plan were denied in writing, or of the completion date of the independent review process if applicable; and

- In the state of Washington or the state where you reside or are employed.

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

WHAT ARE MY RIGHTS UNDER ERISA?

This plan is an employee welfare benefit plan that's subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the "ERISA Plan" in this section.

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

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

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, (if this plan has such an exclusionary period) when 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, if you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. (The Group has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in the plan to the extent stated in our administrative services contract with the Group). No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file

suit in a state or federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either the:

- Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1111 Third Ave. Suite 860, MIDCOM Tower, Seattle, WA 98101-3212; or
- Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan.

Affordable Care Act

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

Allowable Charge

The allowable charge shall mean one of the following:

- **Providers In Washington and Alaska Who Have Agreements With Us**

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

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

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

For covered services and supplies received outside Washington and Alaska, or in Clark County, Washington, allowable charges are determined as stated in the "What Do I Do If I'm Outside Washington And Alaska?" section ("BlueCard® Program And Other Inter-Plan Arrangements") in this booklet.

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

The allowable charge for a provider in Washington or Alaska that doesn't have an agreement with us will be no greater than the maximum allowance that we would have been allowed the medically necessary covered services been furnished by a provider that has an agreement in effect with us. The allowable charge for a provider that doesn't have an agreement with the local Blue Cross and/or Blue Shield Licensee will be no greater than the allowance that that Licensee uses for providers that are not in its network.

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

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us.

Ambulatory Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures

- It doesn't provide inpatient services or accommodations

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Chemical Dependency

An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

Community Mental Health Agency

An agency that's licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.

Complication Of Pregnancy

A condition which falls into one of the 3 categories listed below that requires covered, medically necessary services which are provided in addition to, and greater than, those usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition.

- Diseases of the mother which are not caused by pregnancy, but which coexist with and are adversely affected by pregnancy
- Maternal conditions caused by the pregnancy which make its treatment more difficult. These conditions are limited to:
 - Ectopic pregnancy
 - Hydatidiform mole/molar pregnancy
 - Incompetent cervix requiring treatment
 - Complications of administration of anesthesia or sedation during labor or delivery
 - Obstetrical trauma uterine rupture before onset or during labor
 - Ante- or postpartum hemorrhage requiring medical/surgical treatment
 - Placental conditions which require surgical intervention
 - Preterm labor and monitoring

- Toxemia
- Gestational diabetes
- Hyperemesis gravidarum
- Spontaneous miscarriage or missed abortion
- Fetal conditions requiring in utero surgical intervention

Congenital Anomaly Of A Dependent Child

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

Cost-Share

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

Custodial Care

Any portion of a service, procedure or supply that is provided primarily:

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

Effective Date

The date when your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

Eligibility Waiting Period

The length of time that must pass before an employee or dependent is eligible to be covered under the Group's health care plan. If an employee or dependent enrolls under the "Special Enrollment" provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

Emergency Care

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and

facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.

Enrollment Date

For a subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's eligibility date as determined by the plan. There is one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn't provide coverage under this plan, but was later transferred to a class of employees to which the Group does provide coverage under this plan, the enrollment date is the date the subscriber entered the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.) For subscribers who don't enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.

Essential Health Benefits

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

Experimental/Investigational Services

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

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board

- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards set in the definition of "Oncology Clinical Trials" below in this section will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

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

Group

The entity that sponsors this self-funded plan.

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A "hospital" will never be an institution that's run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition or pregnancy.

Injury

Physical harm caused by a sudden event at a specific time and place. It's independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical Emergency

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

Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It's of no use in the absence of illness or injury.

Medical Facility (also called "Facility")

A hospital, skilled nursing facility, state-approved chemical dependency treatment program or hospice.

Medically Necessary

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

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

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

Member (also called "You" and "Your")

A person covered under this plan as a subscriber or dependent.

Network Provider

A provider that is in one of the networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Non-Network Provider

A provider that is not in one of the provider networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Voluntary termination of pregnancy is included as part of obstetrical care.

Oncology Clinical Trials

Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An "oncology clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
- Any drug or device provided as part of a phase I oncology clinical trial
- Services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage.
- Services provided in a clinical trial that are fully funded by another source

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage **before** you enroll in the clinical trial.

Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Outpatient

Treatment received in a setting other than an inpatient in a medical facility.

Participating Pharmacy (Participating Retail/Participating Mail-Order Pharmacy)

A licensed pharmacy which contracts with us or our Pharmacy Benefits Administrator to provide Prescription Drug benefits.

Pharmacy Benefits Administrator

An entity that contracts with us to administer Prescription Drug benefits under this plan.

Physician

A state-licensed:

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

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

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.) licensed in Washington state
- Masters of Social Work (M.S.W.)
- Physician's Assistant (P.A.)

Plan (also called "This Plan")

The Group's self-funded plan described in this booklet.

Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a

medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

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

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

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

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

Provider

A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

Psychiatric Condition

A condition listed in the **Diagnostic and Statistical Manual (DSM) IV** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

Skilled Care

Care that's ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Subscriber

An enrolled employee of the Group. Coverage under this plan is established in the subscriber's name.

Subscription Charges

The monthly rates to be paid by the member that are set by the Group as a condition of the member's coverage under the plan.

Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

We, Us and Our

Means Premera Blue Cross.

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

Contact the Pharmacy Benefit Administrator At

1-800-391-9701
www.medco.com

Customer Service

Mailing Address

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

Physical Address

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

Phone Numbers

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

Local and toll-free TDD number
for the hearing impaired:
1-800-842-5357

When You Have Ideas

Premera Blue Cross
Attn: Customer Assessment Manager
P.O. Box 91059
Seattle, WA 98111-9159

When You Have An Appeal

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

BlueCard

1-800-810-BLUE(2583)

Visit Our Web Site

www.premera.com