



Plan E

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INTRODUCTION

Premera Blue Cross is an Independent Licensee of the Blue Cross and Blue Shield Association. The benefits, limitations, exclusions and other coverage provisions in this booklet are subject to the terms of our contract with the Group named below. This booklet is a part of that contract, which is on file in the Group's office and at Premera Blue Cross. This booklet replaces any other benefit booklet you may have received.

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
- **What If I Have A Question Or An Appeal?** — 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 in Washington and Premera Blue Cross Blue Shield of Alaska in Alaska.

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, we've contracted with a network of health care facilities and professionals. This plan benefits and your out-of-pocket expenses depend on the providers you seek care from. Throughout this section you'll find important information on how to control costs and your out-of-pocket expenses, and how the providers you choose can affect this plan's benefits.

This plan makes available to you sufficient numbers and types of providers to give you access to all covered services in compliance with applicable Washington state regulations governing access to providers. Our provider networks include hospitals, physicians, and a variety of other types of providers.

For care received in Washington, references to "network" in this booklet mean the Heritage network. (See the exception for Clark County in "When You Get Care Outside Washington And Alaska" later in this section.)

For care received in Alaska, references to "network" mean any provider that has signed a contract with Premera Blue Cross Blue Shield of Alaska.

For care received outside Washington and Alaska, references to "network" mean the network described in "When You Get Care Outside Washington And Alaska."

Throughout this booklet, "non-network" refers to a provider who is not in the network applicable for the area. This booklet refers to the benefits payable to network providers as "in-network" benefits and benefits payable to non-network providers as "non-network" benefits.

Your choice of a particular provider may affect your out-of-pocket costs because different providers may have different allowable charges even though they all have an agreement with us or with the same Blue Cross/Blue Shield Licensee. You'll never have to pay more than your share of the allowable charge when you use network providers.

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

For the most current information on Heritage providers, 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.

WHEN YOU GET CARE IN WASHINGTON

You'll always get the highest level of benefits and the lowest out-of-pocket costs when you get covered services and supplies from a Heritage provider. These providers are also familiar with this plan's features and can help you make informed decisions about the health care services you get.

For care received in Clark County, Washington, you also have access to providers through the BlueCard Program. See "When You Get Care Outside Washington and Alaska" later in this section.

Other Providers

If you decide not to use a Heritage provider, you may choose any "provider" (please see the "Definitions" section in this booklet). However, if the provider you choose isn't part of our Heritage provider network, you'll get the lowest level of benefits under this plan for covered services and supplies, unless otherwise stated below.

The following covered services and/or 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.
- Certain types of providers (including Alcohol Treatment Facilities, Blood Banks and Ambulance Companies) with whom we have no agreements. These types of providers aren't included in our Heritage provider directory.
- Services associated with admission by a Heritage provider to a Heritage hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services at any of our contracted hospitals if you're admitted by a Heritage provider who doesn't have admitting privileges at a Heritage-contracted hospital.

Important Note: Please see the "Benefit Level Exceptions For Non-Emergent Care" section for more information on requesting in-network coverage for non-network providers.

Other Important Information About Selecting Providers

Network providers agree to accept the "allowable charge" (please see the "Definitions" section in this booklet) as payment in full. 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 choose doesn't have an agreement with us, you're responsible for amounts above the allowable charge (the difference between

what we allow for the service and the provider's actual 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 don't accrue toward your calendar year deductible.

WHEN YOU GET CARE IN ALASKA

Contracted Providers

You'll always get the highest level of benefits when you get covered services and supplies from providers that have contracts with Premera Blue Cross Blue Shield of Alaska.

To locate a **contracted provider in Alaska**, please contact Customer Service or visit our Web site.

Other Providers

If you decide not to use a **contracted provider**, you may choose any "provider" (please see the "Definitions" section in this booklet). However, if the provider you choose doesn't have a contract with Premera Blue Cross Blue Shield of Alaska, you'll get the lowest level of benefits under this plan for covered services and supplies, unless otherwise stated below.

The following covered services and/or 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.
- Certain types of providers (including Alcohol Treatment Facilities, Blood Banks and Ambulance Companies) with whom we have no agreements. These types of providers aren't included in our provider directory.
- Services associated with admission by a contracted provider to a contracted hospital that are provided by hospital-based providers.

Important Note: Please see the "Benefit Level Exceptions For Non-Emergent Care" section for more information on requesting in-network benefits for non-network providers.

Other Important Information About Selecting Providers

Contracted providers in Alaska agree to accept the "allowable charge" (please see the "Definitions" section in this booklet) as payment in full. 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 choose doesn't have an agreement with us, you're responsible for amounts above the allowable charge (the difference between what we allow for the service and the provider's actual 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 don't accrue toward your calendar year deductible.

WHEN YOU GET CARE OUTSIDE WASHINGTON AND ALASKA

Care you receive outside Washington and Alaska or in Clark County Washington is available through the BlueCard Program.

PPO Providers

To locate a PPO provider through the BlueCard Program, please call the BlueCard number shown on the back cover of your booklet. PPO providers have agreements with other Blue Cross and/or Blue Shield Licensees. The BlueCard Program network consists of hospitals, doctors, and other medical health care providers (for more information, please see the "What Do I Do If I'm Outside Washington And Alaska?" section in this booklet).

You'll always get the highest level of benefits and lowest out-of-pocket costs when you get covered services and supplies from PPO providers through the BlueCard Program.

Other Providers

If you decide not to use a PPO provider, you may choose any "provider" (please see the "Definitions" section in this booklet). However, if the provider you choose isn't part of the BlueCard Program's PPO provider network, you'll get the lowest level of benefits under this plan for covered services and supplies, unless otherwise stated below.

The following covered services and/or 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.
- Certain types of providers that Blue Cross and/or Blue Shield Licensees don't offer provider agreements to.
- Services associated with admission by a PPO provider to a PPO hospital that are provided by hospital-based providers.
- Covered services received from providers located outside the United States, Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

Important Note: Please see the "Benefit Level Exceptions For Non-Emergent Care" section for more information on requesting the in-network level of benefits for other services of non-network providers.

Other Important Information About Selecting Providers

If the provider you choose has an agreement with the local Blue Cross and/or Blue Shield Licensee, you're responsible for applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies.

If the provider you choose doesn't have an agreement with the local Blue Cross and/or Blue Shield Licensee, you're responsible for the difference between the provider's actual charge and the local Blue Cross and/or Blue Shield Licensee's maximum allowance. If no such local allowance applies, you're responsible for the difference between the actual charge and the maximum amount we would have allowed if the provider had an agreement with us. You're also responsible for your normal cost share of the claim costs (see the "What Are My Benefits?" section for further detail).

BENEFIT LEVEL EXCEPTIONS FOR NON-EMERGENT CARE

A "benefit level exception" is our 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 we approve the request, 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 we deny the request, 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.

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 calendar year deductible, if any, and 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

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.

Once the family deductible is met, your individual deductible will 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

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"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 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.

Emergency Room Copay

For each emergency room visit, you pay \$150. Emergency room visits are also subject to any applicable in-network calendar year deductible and coinsurance. The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

Professional Visit Copay

For each office or home visit furnished by a network provider, you pay \$25. In addition to the copay, these services are subject to the calendar year deductible and coinsurance, except as described below.

For most services you will only pay the \$25 copay for the **first 4** visits in a home or office setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, office and home visits from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent visits in a home or office setting from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

Visits to network providers for the services listed below don't count toward the 4-visit limit and are never subject to your deductible or coinsurance. When the services listed below are received in a

home or office setting, you pay only the Professional Visit Copay:

- Acupuncture
- Biofeedback (see the "Professional Visits and Services" benefit for details on when biofeedback is covered)
- Chemical dependency treatment
- Mental health care
- Neurodevelopmental therapies
- Nutritional therapy
- Rehabilitative and chronic pain care
- Spinal and other manipulations
- Exams covered under the Vision Exams benefit, if this benefit is included in the plan. When included, a description of the Vision Exams benefit will appear in the "Special Benefits" section later in this booklet.

Certain benefits provide a limited number of professional visits each calendar year. These limits apply, regardless of whether a given visit falls within the first four visits of the calendar year.

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.

You don't pay a Professional Visit Copay for the visits below:

- Diabetes health education and training
- Emergency room visits
- Home health or hospice care
- Professional services received while an inpatient in a facility
- Outpatient professional services received from an outpatient department of a hospital or facility
- Psychological and neuropsychological testing
- Surgical services

See the specific benefit descriptions later in this section for amounts you are responsible to pay for these services.

WHAT'S MY CALENDAR YEAR DEDUCTIBLE?

Individual Calendar Year Deductible

For each member, this amount is \$500.

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

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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 \$1,500.

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 choose network providers, your coinsurance is 20% of allowable charges.

When you choose non-network providers, your coinsurance is 50% 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 Diabetes Health Education benefit
- The Diagnostic Services benefit
- The Diagnostic and Screening Mammography benefit
- The Emergency Room Services benefit
- The Prescription Drugs benefit
- The Preventive Medical Care benefit
- The Transplants benefit

WHAT'S MY OUT-OF-POCKET MAXIMUM?

Individual Maximum

For each member, this amount is \$3,000 per calendar year.

Family Maximum

For each family, this amount is \$9,000 per calendar year.

DOES MY PLAN HAVE A LIFETIME MAXIMUM?

The lifetime maximum amount of benefits for

services described in this booklet that are available to any one member is \$2,000,000.

Annual Restoration Each January 1 of your continuous coverage, we will restore up to \$5,000 of your lifetime maximum that has been paid by us and not previously restored. This restoration occurs regardless of the state of your health.

The following benefits don't accrue to your lifetime maximum:

- Benefits described in the "Prescription Drugs" section
- Benefits described in the Vision Hardware benefit if this benefit is included in the plan. When included, a description of this benefit will appear in the "Special Benefits" section later in this booklet.

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 \$25 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

Inpatient Facility Services

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 services are provided by a network provider.

Outpatient Facility Services

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

Outpatient Professional Visits

When you see a network provider, you pay a \$25 copay for each visit in an office setting.

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

Please Note: If chemical dependency 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 inpatient and outpatient chemical dependency treatment and supporting

services provided to a member up to a maximum benefit of \$14,500 per member, in any 24-consecutive-month period. This period begins on the first day of covered treatment. Covered services must be furnished by a state-approved treatment program.

In determining whether services for chemical dependency treatment are medically necessary, we'll use the current edition of the **Patient Placement Criteria for the Treatment of Substance Related Disorders** as published by the American Society of Addiction Medicine.

Please Note: Benefits for medically necessary detoxification services are provided under the Emergency Room Services and Hospital Inpatient Care benefits and don't accrue toward the chemical dependency treatment benefit maximum above.

This 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, except as deemed medically necessary by us
- 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

For these services, you will pay only the \$25 copay for the **first 4** visits in an office or home setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, visits in an office or home setting from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent home and office visits from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

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 \$25 copay. 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

For these services, you will pay only the \$25 copay for the **first 4** visits in an office or home setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, visits in an office or home setting from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent home and office visits from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

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.

For these services, you will pay only the \$25 copay for the **first 4** visits in an office or home setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, visits in an office or home setting from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent home and office visits from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

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, in our judgment, 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 our 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 one 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 or coinsurance when you use a network provider. Preventive diagnostic services are laboratory and imaging services done for preventive or screening purposes, based on the U.S. Preventive Services Task Force (USPSTF) guidelines. (A list of these services is available on our Web site or by contacting us.) Examples are cholesterol screening, home colon cancer test, prostate cancer screening and pap smears.

When you use a network provider, benefits for all other diagnostic services are subject to your calendar year deductible and coinsurance.

If you see a non-network provider, benefits for all diagnostic 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 Diagnostic Services benefit covers diagnostic services, including administration and interpretation. Some examples of what's covered are:

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

Please Note:

- Diagnostic surgeries, including scope insertion procedures, such as an endoscopies or colonoscopies, can only be covered under the Surgical Services benefit.
- Allergy testing is covered only under the Professional Visits and Services benefit.
- When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit.
- When outpatient diagnostic services 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.

For mammography services, please see the Diagnostic and Screening Mammography benefit.

Diagnostic and Screening Mammography

Benefits for these services aren't subject to your calendar year deductible or coinsurance, 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

You pay a \$150 copay per visit to the emergency room. Benefits for these services are also subject to your in-network calendar year deductible and coinsurance.

Please Note: The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

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; these services don't accrue toward the Chemical Dependency Treatment benefit maximum. 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.

Health Management

These services are provided at 100% of allowable charges, and are covered up to the benefit limits specified.

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 provided for the following outpatient health education services **and** community wellness classes and programs up to a combined maximum benefit of \$250 per member each calendar year.

The health education maximum doesn't apply to health education and training to manage diabetes. Nicotine dependency program benefits are provided up to a separate maximum benefit of \$500 per member each calendar year.

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 asthma, pain management, childbirth and newborn parenting and lactation.

Diabetes Health Education

Benefits are provided for outpatient health education and training services to manage the condition of diabetes. Benefits for these services aren't subject to a calendar year benefit limit.

Community Wellness

Community wellness classes and programs that promote positive health and lifestyle choices are also covered. Examples of these classes and programs are adult, child, infant and CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety and parenting skills. You pay for the cost of the class or program and send us proof of payment along with a reimbursement form. When we receive these items, we'll provide benefits as stated in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

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, we'll 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.

Prescription drugs for the treatment of nicotine dependency are also covered under this plan. Please see the Prescription Drugs benefit.

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

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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 Your Balance - Plan E
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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. These services don't accrue toward the Chemical Dependency Treatment benefit maximum

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, in our judgment, 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

For these services, you will pay only the \$25 copay for the **first 4** visits in an office or home setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, visits in an office or home setting from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent home and office visits from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

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 (not subject to the benefit maximum stated in the Medical Equipment and Supplies benefit)
- 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.

Benefit Maximum Benefits are provided up to a maximum of \$10,000 per member each calendar year. This maximum does not apply to equipment, supplies, foot orthotics and therapeutic shoes that are prescribed for the treatment of diabetes.

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. We 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, we'll 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.

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

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.

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. These items accrue toward the \$10,000 maximum benefit described above. Items prescribed for the treatment of diabetes are not subject to these benefit limits.

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
- 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. Benefits for inpatient care are subject to the same calendar year deductible and coinsurance as you would pay for inpatient facility and professional services for other covered medical conditions. When you use a network provider, benefits for office visits are subject to the Professional Visit Copay of \$25 per visit.

Please Note: If services and supplies are furnished by a non-network medical 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.

Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition. 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 as determined by us.

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.)
- 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.

Covered services may also be furnished by a state hospital operated and maintained by the state of Washington for the care of the mentally ill.

Benefits are provided up to the following maximums:

Inpatient Care

Up to 10 days per member each calendar year for facility and professional care. As an alternative to inpatient care, this plan covers "psychiatric partial days." Two psychiatric partial days will count as one inpatient day.

Outpatient Therapeutic Visits

Up to 20 office or home therapeutic visits per member each calendar year. Also covered under this benefit are 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 **Physician's Current Procedural Terminology**, published by the American Medical Association.

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.

This 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
- Services furnished in connection with obesity, even if the obesity is affected by psychological factors
- 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, in our judgment, 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.

Outpatient Facility Care

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

Outpatient Professional Services

When you see a network provider, you pay a \$25 copay for each visit in an office setting.

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.

We 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 Medical 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

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

When you see a network provider, you pay a \$25 copay for each visit in an office setting.

For these services, you will pay only the \$25 copay for the **first 4** visits in an office or home setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, visits in an office or home setting from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent home and office visits from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

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

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.

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

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

Nutritional Therapy

When you see a network provider, you pay a \$25 copay for each visit in an office setting.

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

deductible and coinsurance.

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. Nutritional therapy for conditions other than diabetes is limited to 4 visits per member each calendar year. Nutritional therapy for the condition of diabetes isn't subject to a calendar year benefit limit.

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.

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.

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.

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

Benefits are provided for routine and preventive services performed on an outpatient basis, including immunizations, and aren't subject to a calendar year benefit limit. **This benefit will be provided only when the following covered services are furnished by network providers.**

Routine or Preventive Exams

When you see a network provider, you pay a \$25 copay for each visit.

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You will pay only the \$25 copay if your preventive exam is among the **first 4** office or home visits from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, office or home visits from network providers combined count toward the 4-visit limit.

If your preventive exam is not among the first 4 visits, it will be subject to the \$25 copay plus the calendar year deductible and coinsurance.

Immunizations

Benefits for immunizations done by a network provider aren't subject to the Professional Visit Copay or your calendar year deductible or coinsurance.

Covered exam services include:

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

For outpatient routine or preventive diagnostic services (including x-ray), screening and diagnostic mammography, and laboratory services benefit information, please see the Diagnostic Services benefit and the Diagnostic and Screening Mammography benefit.

Services that are related to a specific illness, injury or definitive set of symptoms are covered under the non-preventive medical benefits of this plan.

This benefit doesn't cover:

- Services not named above as covered
- Charges for preventive medical services that exceed what's covered under this benefit
- 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
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations

Professional Visits and Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home. Covered services include second opinions for any covered medical diagnosis or treatment plan when provided by a

qualified provider. Professional visits for diabetic foot care and repair of a dependent child's congenital anomaly are also covered under this benefit. Biofeedback is covered for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see "Definitions").

When you see a network provider, you will pay only the \$25 copay for the **first 4** visits in a home or office setting each calendar year, except as described below. The first 4 visits are an aggregate total, meaning that for each member, office or home visits from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent visits from network providers in a home or office setting are subject to the \$25 copay plus the calendar year deductible and coinsurance.

Exams and visits to non-network providers are always subject to the out-of-network deductible and coinsurance.

Certain benefits provide a limited number of professional visits each calendar year. These limits apply, regardless of whether a given visit falls within the first 4 visits of the calendar year.

The following services don't count toward the 4-visit limit but are subject to a \$25 copay for each visit when done by a network provider in an office or home setting. They are:

- Acupuncture services
- Biofeedback, as described earlier in this benefit
- Chemical dependency treatment
- Mental health care
- Neurodevelopmental therapies
- Nutritional therapy
- Rehabilitative and chronic pain care
- Spinal and other manipulations
- Exams covered under the Vision Exams benefit, if this benefit is included in the plan. When included, a description of the Vision Exams benefit will appear in the "Special Benefits" section later in this booklet.

Some professional services are not subject to the Professional Visit copay. The amounts you pay for these services when you see a network provider are explained under other benefits in this booklet. These services are:

- Health management services
- Emergency room visits
- Home health or hospice care
- Professional services received while an inpatient in a facility

- Outpatient professional services received in an outpatient department of a hospital or facility
- Psychological and neuropsychological testing
- Surgical services

Therapeutic Injections And Allergy Tests

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

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

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

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

This benefit doesn't cover:

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

Psychological and Neuropsychological Testing

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.

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.

Outpatient Facility Care

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

Outpatient Professional Services

When you see a network provider, you pay a \$25 copay for each visit in an office setting.

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

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

We 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.

Skilled Nursing Facility Services

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

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 \$25 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.

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.

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.

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

When you see a network provider, you pay a \$25 copay for each visit in an office setting.

For these services, you will pay only the \$25 copay for the **first 4** visits in an office or home setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, visits in an office or home setting from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent home and office visits from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

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.

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), unless you've been covered under a medical contract with us for 6 consecutive months. However, this waiting period doesn't apply if the transplant is needed as a direct result of:

- An injury that occurs on or after your effective date of coverage under this plan
- A congenital anomaly of a child who's been covered through us since birth
- A congenital anomaly of a child who's been covered through us since placement for adoption with the subscriber

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).

Covered Transplants

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

When you see a network provider or an approved transplant provider, you pay a \$25 copay for each visit in an office setting.

For these services, you will pay only the \$25 copay for the **first 4** visits in an office or home setting from network providers each calendar year. The first 4 visits are an aggregate total, meaning that for each member, visits in an office or home setting from network providers combined count toward the 4-visit limit.

After the 4-visit limit is reached, subsequent home and office visits from network providers are subject to the \$25 copay plus the calendar year deductible and coinsurance.

When a professional visit isn't provided in an office setting, benefits are subject to your 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.") We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our 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)

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 our 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.

- The \$250,000 transplant maximum benefit must not have been reached.

Transplant Maximum

This benefit is subject to a lifetime maximum benefit of \$250,000 for all covered transplants and transplant-related services combined. Services that accrue to this lifetime maximum benefit are also subject to the 6-month waiting period stated above.

Recipient Costs

Benefits for transplant or reinfusion related expenses start accruing to the \$250,000 maximum 30 days before the date of a solid organ transplant, or in the case of bone marrow or stem cell procedures, 30 days before the date of reinfusion. Benefits stop accruing to the \$250,000 maximum 180 days from the date of the transplant or reinfusion. Inpatient stays for episodes of rejection related to a solid organ transplant or bone marrow or stem cell reinfusion beyond the 180-day period will also accrue to the \$250,000 maximum. However, the time limits above don't apply to this benefit's coverage for transportation and lodging.

This benefit also provides coverage for 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 charged against the recipient's \$250,000 maximum and are limited to \$75,000 per transplant. Covered 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
- 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 charged against the recipient's \$250,000 maximum and 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

SPECIAL BENEFITS

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.

Retail Pharmacy Prescriptions

Generic Drugs.....	\$10
Preferred List Brand.....	\$30
Name Drugs	
Non-Preferred List Brand.....	\$60
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. Dispensing of up to a 90-day supply is allowed when the drug maker's packaging doesn't allow for a lesser amount. If any prescriptions require a copay, you would be charged an additional copay for each 30-day supply, or the cost of the drug if that cost doesn't exceed the cost of the copay.

Medco By Mail / Mail-Order Pharmacy Program

Generic Drugs.....	\$20
Preferred List Brand.....	\$60

Name Drugs

Non-Preferred List Brand.....\$120

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.

Injectable Supplies

When insulin needles and syringes are purchased along with insulin, only the copay or coinsurance for the insulin will apply.

When insulin needles and syringes are purchased separately, the Preferred List Brand Name Drug copay or coinsurance would apply for each item purchased.

The Preferred List Brand Name Drug copay or coinsurance will apply to purchases for alcohol swabs, test strips, testing agents and lancets. A separate copay will apply to each item purchased.

How To Use The Medco By Mail / Mail-Order Pharmacy Program

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 Medco By Mail. 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.

Retail Pharmacy Benefit

- **Participating Retail Pharmacies** After you've paid any required copay or coinsurance, we'll pay the participating pharmacy directly.

To avoid paying the retail cost for a prescription drug that's reimbursable by us 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 copay or coinsurance, you pay 40% of the allowable charge for the prescription or refill and the difference between the pharmacy's billed charge and our 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.

Medco By Mail / Mail-Order Pharmacy Program

You can often save time and money by filling your prescriptions through the Medco By Mail / Mail-Order Pharmacy program. After you've paid any required copays or coinsurance, we'll pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by Medco By Mail.

For more information on the mail-order pharmacy program, or to obtain order forms, please contact our Customer Service department.

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/or coinsurance required under this benefit don't apply to other benefits of this plan.

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
- 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, up to \$250 per member each calendar year
- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps)

For benefit information concerning 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.

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the Preventive Medical Care benefit.

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 our Specialty Pharmacy provision (see number 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
- Drugs to treat infertility, including fertility enhancement medications

Prescription Drug Volume Discount Program

Your prescription drug benefit program includes per claim rebates that are received by Premera Blue Cross from its pharmacy benefit manager. These rebates are taken into account in setting subscription charges or are credited to administrative charges otherwise payable to us by 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. We either retain the difference and apply it to the cost of our operations and the prescription drug benefit program or credit the difference to subscription rates for the subsequent benefit year. If your prescription drug benefit includes a copayment, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowable charge.

Your Right To Safe And Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service. The phone numbers are shown on the back cover of this booklet.

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Questions and Answers About Your Pharmacy Benefits

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

Your coverage for drugs is not restricted to drugs on a specific list. However, we have

identified an approved list of drugs, made up of generic drugs (as defined below) and certain brand name drugs. We use this approved drug list to aid in the process of contracting for lower drug prices. We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the approved list.

This plan does cover drugs that are not on the approved list on the same basis as approved drugs. However, this plan does not cover certain categories of drugs. These are listed under "Exclusions" earlier in this benefit.

This plan requires the use of appropriate generic drugs. When available, a generic drug (as defined below) will be dispensed in place of a brand name drug. In the event a generic equivalent is not manufactured, the applicable brand name copay or coinsurance will apply. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you'll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the brand name copay or coinsurance. Please consult with your pharmacist on the higher cost you will 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.

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

2. When can my plan change the preferred drug list (formulary)? 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 preferred 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 preferred 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't be changed. Provisions regarding substitution of generic drugs are described above in question #1.

You can appeal any decision you disagree with. Please see the "What If I Have A Question Or An Appeal?" 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. Over 90% of the pharmacies (more than 1,000 individual pharmacies) in Washington are part of our 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 Premera Blue Cross 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 or multiple sclerosis. We have contracted with specific specialty pharmacies that specialize in the delivery and clinical management of specialty drugs. These pharmacies will work with you and your health care provider to arrange ordering and delivery

of these drugs.

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.

In certain circumstances, we may limit benefits to a specific dispensed days' supply, drug, or drug dosage appropriate for a usual course of treatment. We may also limit benefits for certain drugs to specific diagnoses or pharmacies or require prescriptions to be obtained from an appropriate medical specialist. Benefits for certain drugs may be subject to step therapy where you are required to first try a generic or specified brand name drug.

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

Benefits for refills will be provided only when the member has used 75% of the current supply. The 75% is calculated based on the number of units and days supply dispensed on 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?

THE BLUECARD® PROGRAM

Premera Blue Cross, like all Blue Cross and/or Blue Shield Licensees, participates in a program called

"BlueCard." Members can take advantage of BlueCard when they receive covered services in Clark County, Washington or outside Washington and Alaska from hospitals, doctors, and other medical care providers who have contracted with the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. The national BlueCard Program is available throughout the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands.

Your identification card tells contracting providers which independent Blue Cross and/or Blue Shield Licensee covers you. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan. When you use your identification card, you will receive many of the conveniences you're accustomed to from Premera Blue Cross. In most cases, there are no claim forms to submit because contracting providers will handle claim submission for you. In addition, your out-of-pocket costs may be less, as explained below.

Here's How BlueCard Helps Keep Costs Down

When you obtain health care services in Clark County, Washington or outside Washington and Alaska through BlueCard (excluding BlueCard Worldwide; see below), the amount you pay for covered services is calculated on the **lower** of:

- The billed charges for your covered services, or
- The "negotiated price" that the Host Blue passes on to Premera Blue Cross for your covered services.

The methods used to determine the negotiated price will vary among Host Blues according to the terms of their provider contracts. Often, the negotiated price will consist of a simple discount, which reflects the actual price allowed as payable by the Host Blue. But, sometimes, it's an estimated price that factors in aggregate payments expected to result from the Host Blue's settlements, withholds, other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects an **average** expected savings with your health care provider or a specified group of providers. The price that reflects average savings may result in greater variation above or below the actual price than will the estimated price. In accordance with national BlueCard policy, these estimated or average prices will also be adjusted from time to time to correct for overestimation or underestimation of past prices. However, the amount on which your payment is based remains the final price for the covered services billed on your claim.

Some states may mandate a surcharge or a method of calculating what you must pay on a claim that differs from BlueCard's usual method noted above. If such a mandate is in force on the date you received care in that state, the amount you must pay for any covered services will be calculated using the methods required by that mandate. Such methods might not reflect the entire savings expected on a particular claim.

Clark County Providers

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

Non-BlueCard Claim Submission

If a hospital, doctor, or other medical care provider does not contract with the Host Blue, that claim might not be filed on your behalf. For instructions on how to file a claim in this situation, refer to the "How Do I File A Claim?" section of this booklet.

BlueCard Worldwide®

If you're outside the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide. BlueCard Worldwide is unlike the national BlueCard Program in certain ways. For instance, although BlueCard Worldwide provides a network of contracting hospitals, it offers only referrals to doctors and other health care providers. When you receive care from doctors or other health care providers, you will have to submit claim forms on your own behalf to obtain reimbursement for the services provided through BlueCard Worldwide.

To access health care services through BlueCard Worldwide and to obtain additional information about providers' charges, please call 1-800-810-BLUE (2583).

Further Questions?

If you have questions or need additional information about using your identification card in Clark County, Washington or outside Washington and Alaska, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, call 1-800-810-BLUE (2583).

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.

The benefits of this plan don't require preauthorization for coverage. 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 our 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. We may utilize your contract benefits as specified in the signed agreements, but the agreements are not to be construed as a waiver of our right to administer the Group Contract 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.

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).

The waiting period for pre-existing conditions is 3 months from your enrollment date. Except as noted 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 by prior periods of creditable coverage as explained below.

How Creditable Coverage Can Reduce Your Waiting Period For Pre-Existing Conditions

This plan's waiting period for pre-existing conditions may be reduced by periods of "creditable" coverage you've accrued under other health care plans prior to your enrollment date for this plan. Most medical health care coverage is considered creditable coverage (see list below). You'll receive credit for prior creditable coverage that occurred without a break in coverage of more than 3 months. Any coverage you had before a break in coverage which exceeds 3 months isn't credited toward your waiting period for pre-existing conditions. Eligibility waiting periods 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. You may contact our Customer Service department if you're unable to obtain a certificate of health coverage from a prior health plan. 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.

"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 period for pre-existing conditions **doesn't apply** to:

- Pregnancy
- Newborn children born after the subscriber's effective date of coverage under this plan, provided they are covered from birth as explained under the "When Does Coverage Begin?" section.
- Newborn children covered under creditable coverage at any time during the 30-day period beginning with their date of birth. However, the waiting period for pre-existing conditions will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 3 months.
- Adoptive children who are adopted or placed for adoption after the subscriber's effective date of coverage under this plan, provided they're covered from the date of their adoption or placement for adoption as explained under the "When Does Coverage Begin?" section.
- Adoptive children, who before the age of 18, were covered under creditable coverage at any time during the 30-day period beginning with their date of adoption or placement for adoption. However, the waiting period for pre-existing conditions will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 3 months.
- Coverage for PKU dietary formula for members with phenylketonuria.

WAITING PERIOD FOR TRANSPLANTS

Organ, bone marrow and stem cell transplants are subject to a benefit-specific 6-month waiting period. Please see the Transplants benefit for details.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, we 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
- Commercial liability coverage
- Homeowner policy
- Other types of liability insurance
- Worker's Compensation or similar 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 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, and Mental Health Care benefits. 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 the Dental Services or Temporomandibular Joint (TMJ) Disorders benefits. (Please see the "Medical Services" section under "What Are My Benefits?" earlier in this booklet.)

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.

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 "What If I Have A Question Or An Appeal?" 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:

- We approve your request for a benefit level exception for non-emergent care to the facility (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)
- We 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 Prescription Drugs benefit.

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

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, in our judgment, 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, in our judgment, medically necessary to treat your condition

Obesity Services

Treatment of obesity or morbid obesity, including surgery, and any direct or indirect complications and aftereffects thereof; services and supplies connected with weight loss or weight control, except for health education and wellness classes or programs specified as covered under the Health Management benefit and for services to treat diabetes covered under the Nutritional Therapy benefit. This exclusion applies even if you also have an illness or injury that might be helped by weight loss.

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
- Services and supplies that aren't directly related to your illness, injury or distinct physical symptoms. Examples are routine physical examinations and diagnostic surgery. However, this exclusion doesn't apply to services and supplies specified as covered under the following benefits:
 - Diagnostic Services
 - Diagnostic and Screening Mammography
 - Newborn Care (including well-newborn care)

- Preventive Medical Care (including well-baby care)
- Health Management

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 Exams

Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware are only covered as described under the Vision Exams benefit, if this plan includes one. When included, a description of the Vision Exams benefit will appear in the "Special Benefits" section earlier in this booklet.

Vision Hardware

Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies are only covered as described in the Vision Hardware benefit, if this plan includes one. When included, a description of the Vision Hardware benefit will appear in the "Special Benefits" section earlier in this booklet.

This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. 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 Association Employer if they're exempt from the above laws and if the Association Employer doesn't furnish them with Workers' Compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Association Employer. Coverage is subject to the other terms and limitations of this plan.

WHAT IF I HAVE OTHER COVERAGE?

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

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

When you have more than one health plan, "coordination of benefits (COB)" makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims with each plan at the same time. If you have Medicare, Medicare may submit your claims to your secondary plan.

Definitions

For the purposes of COB:

- A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the

contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB doesn't apply is treated as a separate plan.

- "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.
- "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.
- **This plan** means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your Premiera Blue Cross-plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.
- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See "Effect On Benefits" later in this section for rules on secondary plan benefits.
- **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that isn't covered by any of your plans isn't an allowable expense.
An example of an expense that is **not** allowable is any amount over the highest of the expense amounts allowed by either the primary or secondary plan. This is true regardless of what method the plans use to set allowable expenses. However, when Medicare or a Medicare Advantage plan is primary to your other coverage,

the allowable expense set by Medicare or the Medicare Advantage plan must be treated as the highest allowable.

- **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.

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 Washington regulations is primary to a complying plan unless the rules of both plans make the complying plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

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

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

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

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
 - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.
 - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses,

the plan of the parent with financial responsibility is primary.

- If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
 - The plan covering the custodial parent, first
 - The plan covering the spouse of the custodial parent, second
 - The plan covering the non-custodial parent, third
 - The plan covering the spouse of the non-custodial parent, last
- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

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

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

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

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

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

COB's Effect On Benefits

The primary plan provides its benefits as if you had no other coverage.

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. For each claim, the

benefits of the primary and secondary plans must total 100% of the highest allowable expense allowed for the service or supply by either plan. **However, the secondary plan is never required to pay more than its benefit in the absence of COB plus any savings accrued from prior claims incurred in the same calendar year.**

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary. It must also calculate savings for each claim by subtracting its secondary benefits from the amount it would have provided as primary. It must use these savings to pay any allowable expenses incurred during that calendar year, whether or not they are normally covered.

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the consent of anyone to do this. State regulations require each of your other plans and each person claiming benefits under this plan to give us any facts we need for COB.

Right Of Recovery/Facility Of Payment If your other plan makes payments that this plan should have made, we have the right, at our discretion, to remit to the other plan the amount we determine is needed to comply with COB. To the extent of such payments, we are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess payment from anyone to whom or for whom the payment was made or from any other issuers or plans.

Questions about COB? Contact our Customer Service Department or the Washington Insurance Department.

Coordinating Benefits With Medicare

If you're also covered under Medicare or TRICARE, federal law may require this plan to be primary.

When this plan isn't primary, we'll coordinate benefits with Medicare or TRICARE.

SUBROGATION AND REIMBURSEMENT

If we make 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, we will be subrogated to any rights that you may have to recover compensation or damages from that liable party related to the injury or illness, and we would be entitled to be repaid for payments we made on your behalf out of any recovery that you obtain from that liable party after you have been fully compensated for your loss. The liable party is also known as the

"third party" because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tortfeasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss.

To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of payments we have made on your behalf after you have been fully compensated for your loss. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. In recovering payments made on your behalf, we may at our election hire our own attorney to prosecute a subrogation claim for recovery of payments we have made on your behalf directly from third-parties, or be represented by your attorney prosecuting a claim on your behalf. Our right to prosecute a subrogation claim against third-parties is not contingent upon whether or not you pursue the party at fault for any recovery. If you recover from a third party and we share in the recovery, we will pay our share of the legal expenses. Our share is that percentage of the legal expenses necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. In the event of a trial or arbitration, you must make a claim against, or otherwise pursue recovery from third-parties payments we have made on your behalf, and give us reasonable notice in advance of the trial or arbitration proceeding. You must also cooperate fully with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent

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to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of the payments we have paid on your behalf, you are responsible for reimbursing us for payments we have made on your behalf.

You agree, if requested, to hold in trust and execute a trust agreement in the full amount of payments we made on your behalf from any recovery you obtain from any third-party until such time as we have reached a final determination or settlement regarding the amount of your recovery that fully compensates you for your loss.

Agreement To Arbitrate Any disputes that arise as part of this provision will be resolved by arbitration. Both you and we 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 contract, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

We have 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. We have the discretionary authority to determine your eligibility for benefits.

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, or corporate officer of the Association Employer who is paid on a regular basis through the Association Employer's payroll system, and reported by the Association Employer for Social

Security purposes. The employee must also meet 2 other requirements. The employee must:

- Regularly work the minimum hours required by the Association Employer
- Complete the probationary period, if any, required by the Association Employer

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. However, if the spouse is an owner, partner, or corporate officer of the Association Employer who meets the requirements in "Subscriber Eligibility" earlier in this section, the spouse can only enroll as a subscriber.
- The domestic partner of the subscriber. If all requirements are met, as stated in the signed "Affidavit of Domestic Partnership," 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 child under 25 years of age and unmarried who is also partially or totally dependent on the subscriber for support. (Eligibility and enrollment requirements for children placed for adoption and children covered because of a court decree can be found later in this section.) 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 living permanently in the home of the subscriber

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

If we don't receive the enrollment application within 60 days of the date you became eligible, none of the dates above will 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 first of the month following 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 Association Employer for detailed procedures.

SPECIAL ENROLLMENT

Involuntary Loss of Other Coverage

If you don't enroll in this plan or another plan sponsored by the Group when you are eligible because you aren't required to do so, you may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

- You were covered under group health coverage or a health insurance plan at the time coverage under the Group's plan is offered
- Your 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, or reaching a health care plan's overall lifetime benefit maximum
 - Termination of employer contributions toward such coverage
 - You were covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted

In addition, if you were covered under another health plan sponsored by the Group, and you reach that plan's lifetime maximum, you also have the right to enroll in this plan if one of two things is true:

- The lifetime maximum of this plan is higher than that of the other plan
- The benefits paid under the other plan could not be credited toward this plan's lifetime maximum. (See "Plan Transfers" later in this section for credits applied for transfers between two Premera Blue Cross plans.)

When we receive your completed enrollment application and any required subscription charges from the Group within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of your enrollment application.

If we don't receive your completed enrollment application within 30 days of the date prior coverage ended, please see the "Open Enrollment" provision later in this section.

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.

Persons Eligible For Medical Assistance

When the Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective to enroll in this plan, a person who is eligible for state medical assistance and who is also eligible for coverage under this plan, we will enroll the person as a special enrollee. Coverage will start on the first of the month following the date we receive the application for coverage. In order to apply for coverage, you may be required to provide the notice of eligibility you received from DSHS.

An eligible employee who elected not to enroll in this plan when such coverage was previously offered, must enroll in this plan in order for any otherwise eligible dependents to be enrolled in accordance with this provision. Coverage for the employee will start on the date the dependent's coverage starts.

OPEN ENROLLMENT

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

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

CHANGES IN COVERAGE

No rights are vested under this plan. Its terms, benefits and limitations may be changed by us 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 with us offered by the Association Employer. Transfers also occur if the Group or Association Employer replaces another plan (with us) with this plan. All transfers from another plan offered by the same Association Employer must occur during open enrollment or on another date agreed upon by us and the Group.

When we update the contract for this plan, or you transfer from the Association Employer's other plan with us, 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:

- Waiting period for pre-existing conditions
- Transplant waiting period
- Out-of-pocket maximum
- Benefit maximums
- Lifetime maximums
- Calendar year deductible. Please note: This plan may apply only expenses incurred in the current calendar year to the current year's calendar year deductible. (See "Fourth Quarter Carryover" in the "What's My Calendar Year Deductible?" section to find out.) If so, we would credit expenses that were applied to your prior plan's calendar year deductible **only** when they were incurred during the current calendar year. We would not credit toward this plan's calendar year deductible expenses incurred during October through December of the prior year.

This provision does not apply to transfers from plans not offered by us.

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 Group contract is terminated
 - The next monthly subscription charge isn't paid when due or within the grace period
 - The subscriber dies or is otherwise no longer eligible as a subscriber

- The Association Employer's membership in the association ceases
- In the case of a collectively bargained plan, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
- 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 Association Employer when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. We must receive written notice of a member's termination within 30 days of the date the Association Employer is notified of such event.

CERTIFICATE OF HEALTH COVERAGE

When your coverage under this plan terminates, you'll receive a "Certificate of Health Coverage." The certificate will provide information about your coverage period under this plan. When you provide a copy of the certificate to your new health plan, you may receive credit toward any waiting period for pre-existing conditions. You'll need a certificate each time you leave a health plan and enroll in a plan that has a waiting period for pre-existing conditions. Therefore, it's important for you to keep the certificate in a safe place.

If you haven't received a certificate, or have misplaced it, you have the right to request one from us or your former employer within 24 months of the date coverage terminated.

When you receive your Certificate of Health Coverage, make sure the information is correct. Contact us or your former employer if any of the information listed isn't accurate.

Documents that may establish creditable coverage in the absence of a certificate include explanations of benefit claims or correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

CONTRACT TERMINATION

No rights are vested under this plan. Termination of Your Balance - Plan E
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the Group Contract for this plan completely ends all members' coverage and all our obligations, except as provided under "Extended Benefits"; please see the "How Do I Continue Coverage?" section below.

This plan is guaranteed renewable. However, this plan will automatically terminate if subscription charges aren't paid when due; coverage will end on the last day for which payment was made. This plan may also terminate as indicated below.

The Group may terminate the Group Contract:

- Upon 30 days' advance written notice to us on any subscription charge due date
- By rejecting in writing the contract changes we make after the initial term. The written rejection must reach us at least 15 days before the changes are to start. The Group Contract will end on the last date for which subscription charges were paid.

We may terminate the Group Contract, **upon 30 days advance written notice to the Group if:**

- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage
- The Group fails to meet the minimum participation or contribution requirements stated in its signed application
- The Group no longer has any members who reside or work in Washington
- Published policies, approved by the Office of the Insurance Commissioner, have been violated
- There is a material breach of the Group Contract, other than non-payment
- We are otherwise permitted to do so by law

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age (shown under "Dependent Eligibility") for an unmarried 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 us with a Request for Certification of Handicapped Dependent form. We 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 we request it. We won't ask for proof 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 Association Employer 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 certain Association Employers 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 the subscription charges for it. The Association Employer is responsible to notify you whether it meets the standards set by the federal COBRA laws and regulations.

At the Group's request, we'll provide qualified members of Association Employers that are subject to COBRA with COBRA coverage under this plan 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. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us or the Association Employer's failure

to perform COBRA-related duties. The Association Employer, **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 Association Employer 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 Association Employer 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 Association Employer 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 Association Employer 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 Association Employer 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 Association Employer receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Association Employer 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 Association Employer 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 Association Employer 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 Association Employer. 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 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 Association Employer 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 Association Employer must tell you where to direct your notice and any other procedures that you must follow. If the Association Employer 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 Association Employer.

The Association Employer must notify qualified members of their rights under COBRA. If the Group or Association Employer 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 Association Employer (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Association Employer itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Association Employer 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 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 Association Employer 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.

If you're not notified of your right to elect COBRA

coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you're not notified of your right to elect COBRA coverage within the time limit, and you don't elect COBRA coverage within 60 days after the date coverage ends, we won't be obligated to provide COBRA benefits under this plan. The Association Employer will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.

- You must send your first subscription charge payment to the Association Employer no more than 45 days after the date you elected COBRA coverage.
- Subsequent subscription charges must be paid to the Association Employer and submitted to us with the Group's regular monthly billings.

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." 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 Association Employer Informed Of Address Changes

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

When COBRA Coverage Ends

COBRA coverage will end on the last day for which subscription charges have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly subscription charge 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 Association Employer with a copy of the 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. If, however, 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 Association Employer 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 or the date that coverage under this plan ends for the Association Employer.

When COBRA coverage under this plan ends, you may be eligible for benefits as described in "Extended Benefits" later in this section. You may also be eligible to apply for one of our Conversion plans as explained in "Converting To A Non-Group Plan".

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Association Employer. For more information about your rights under federal 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.

6-MONTH CONTINUATION OF GROUP COVERAGE

You may choose to extend your coverage under this plan for up to 6 months past the date your coverage ended if:

- Your Association Employer isn't subject to COBRA
- You're not eligible for COBRA coverage
- Your group coverage ends for reasons other than rescission

You must send your first subscription charge payment and completed "Continued Coverage" application to the Association Employer by the due date determined by the Group. The Group will in turn send us your subscription charge payment and completed "Continued Coverage" application form with the first payment it makes on or after the date your coverage ended. Subsequent subscription charge payments must be paid to the Association Employer, by the date determined by the Group, and forwarded to us by the Group with their regular monthly billings.

Continued coverage under this plan may end before the 6-month period expires. It will end on the last day of the monthly period for which subscription charges have been paid in which the first of the following occurs:

- The next monthly subscription charge isn't paid when due or within the grace period
- The contract between the Group and us is terminated
- The Association Employer's coverage under this plan is terminated

The 6-month continuation period isn't available once COBRA coverage is exhausted.

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than rescission. If the contract between the Group and us is terminated while you're receiving the extended benefits below, your right to those benefits won't be affected.

Extended Inpatient Benefits

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

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

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

Newborn Care benefit.

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

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

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.

CONVERTING TO A NON-GROUP PLAN

You may be entitled to coverage under one of our Conversion plans when your coverage under this plan ends. Conversion plans are individual plans that differ from this plan. You pay the monthly payment. You must apply and send the first subscription charge payment to us within 31 days of the date your coverage ends under this plan.

You can apply for a Conversion plan if you live in Washington State and you're not eligible for Medicare coverage, and one of 2 things is true:

- You're not entitled to services or benefits for

medical and hospital care under another group plan.

- You're entitled to other coverage, but that coverage contains exclusions or waiting periods for any pre-existing conditions you have.

For more information about our Conversion plans, contact your employer or our Customer Service department.

Please Note: The rates, coverage and eligibility requirements of our Conversion plans differ from those of your current group plan. In addition, enrollment in a Conversion plan may limit your ability to later purchase an individual plan without a pre-existing condition waiting period.

MEDICARE SUPPLEMENT COVERAGE

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you **may** be eligible for guarantee-issued coverage under certain Medicare supplement plans if you apply within 63 days of losing coverage under this plan. For more information, contact your agent or our Customer Service department.

HOW DO I FILE A CLAIM?

Medical Claims

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

Step 1

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

Step 2

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

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or ICD-9 code
- Procedure codes (CPT-4, HCPCS, ADA or UB-92) or descriptive English nomenclature for each service
- Dates of service and itemized charges for each

service rendered

- If the services rendered are for treatment of an injury, the date, time, location and a brief description of the event

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

Prescription Drug Claims

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

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

We won't provide benefits for claims we receive after the later of these 2 dates, nor will we 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 we may need to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of our complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter from our medical department stating these reasons. The letter will also include how ongoing care may be covered during the appeal process, as described in "When You Have An Appeal" below.

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 your Association Employer is subject to ERISA, ERISA gives you the right to file suit in a state or federal court if a claim for benefits or an appeal is

Your Balance - Plan E
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denied or ignored, in whole or in part, or not processed within the time shown in these claims procedures.

WHAT IF I HAVE A QUESTION OR AN APPEAL?

As a Premera Blue Cross member you have the right to offer your ideas, ask questions, voice complaints and submit appeals. Our goal is to listen, resolve your problems, and improve our service to you.

When You Have Ideas

We want to hear from you on ways we can continue to improve our service. If you have an idea, suggestion or opinion, please let us know. You can call our Customer Service department at the numbers listed on the back cover of this booklet, or send your ideas and comments to our Customer Assessment Manager at the Customer Service address on the back cover of this booklet.

When You Have Questions

Call your provider of care when you have questions about the health care services you receive. Please call our Customer Service department with any other questions regarding your Premera Blue Cross plan.

When You Have A Complaint

A **complaint** is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but don't require, that you take advantage of this process when you're not content with a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, a representative will tell you.

When you have a complaint, call or write our Customer Service department. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We'll let you know when we've received your complaint. We also may request more information when needed. When we receive all needed information, we'll review your complaint and respond as soon as possible, but never more than 30 calendar days.

When You Have An Appeal

An **appeal** is an oral or written request that we reconsider 1) our decision on a complaint, or 2) our

decision to deny, modify, reduce, or end payment, coverage or authorization of coverage. This includes admissions to and continued stays in a facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you're appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

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

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

You may mail appeals to our Appeals Coordinator at the Appeals address shown on the back cover of this booklet.

Appeals Process

Our standard appeals process has 2 levels of review. We'll give you our appeal decisions in writing.

Level I The Level I Appeal panel will give you its decision within 30 calendar days. This panel will include health care providers who weren't involved in the initial decision.

There are 3 exceptions to the 30-day time limit:

- **A decision to change, reduce or end an ongoing service**
We'll mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than an additional 15 calendar days.
- **Denial of an experimental or investigational service**
We'll mail you a response within 20 calendar days from the date we receive your appeal. The 20-day period may be extended for up to 10 more calendar days with your informed written consent.
- **Urgent Appeals** (please see the "Urgent Appeals" provision below)

If you don't agree with the decision reached in our Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. **You must make your request for a Level II review no more than 60 calendar days after the date you receive our Level I decision.** This time limit may be extended in the event the member needs to obtain additional

medical documentation, physician consultations or opinions, if the member is hospitalized or traveling, or for other reasonable cause beyond the member's control. In no case shall the extension exceed 180 days.

Level II Your appeal will be reviewed by a Premier Blue Cross panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. Unless your appeal is deemed urgent (please see the "Urgent Appeals" provision below), the panel will give you a decision within 30 calendar days of the date we receive your Level II request.

If you're appealing a decision to deny, change, reduce or end payment, coverage or authorization of coverage, and you're not satisfied with the outcome of the Level II appeal, you may ask for an independent review (please see the "Independent Review" provision below). You may also ask for an independent review if we don't give you our Level I or Level II decision within the time limits stated. We must receive your request for independent review within 60 calendar days of the date that the appeal decision was due.

If your Association Employer is subject to ERISA. ERISA gives you the right to file suit in federal court if you're not satisfied with the outcome of the Level I or Level II appeal.

Independent Review Independent reviews are conducted by an independent review organization (IRO), which is an organization of medical experts qualified to review your appeal. We'll use IROs that have been certified by the state Department of Health. We'll submit your file to the IRO on your behalf and will pay the charges of the IRO. The IRO will give you its decision in writing. We'll implement the IRO's determination promptly.

Urgent Appeals We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and II responses on urgent appeals will be given within 72 hours after the appeal is received.

Appeals Of Ongoing Care While you're appealing a decision to change, reduce or end coverage because the service or level of service is no longer medically necessary or appropriate, we'll suspend our denial. Our coverage for services received during the appeal period doesn't and shouldn't be construed to reverse our denial. **If our initial decision is upheld, you must repay us all amounts that we've paid for such services. You'll also have to pay providers any difference between our allowable charge and the provider's billed charge.**

Please call Customer Service if you have questions

or need more information about our complaint or appeal process. The numbers are shown on the back cover of this booklet.

Additional Information About Your Coverage

Your benefit booklet provides you with detailed information about this plan's benefits, limitations and exclusions, how to obtain care and how to appeal our decisions.

You may also ask for the following information:

- Your right to seek and pay for care outside of this plan
- The plan's drug list, also called a "formulary"
- How we pay providers
- How providers' payment methods help promote good patient care
- A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations
- How to file a complaint and a copy of our process for resolving complaints
- How to access specialists
- Obtaining preauthorization when needed
- Accreditation by national managed care organizations
- Use of the health employer data information set (HEDIS) to track performance

If you want to receive this information, please go to our Web site. If you don't have access to the Web, please call Customer Service. Our Web address and phone numbers are shown on the back cover of this booklet.

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how your Group's contract with us and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

Conformity With The Law

The Group Contract is issued and delivered in the state of Washington and is governed by the laws of the state of Washington, except to the extent pre-empted by federal law. If any provision of the Group Contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Group Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Member Cooperation

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

Entire Contract

The entire contract between the Group and us consists of all of the following:

- The contract face page and Standard Provisions
- This benefit booklets
- The Group's signed application
- The Funding Arrangement Agreement between the Group and us
- All attachments, endorsements and riders included or issued hereafter

No agent or representative of Premera Blue Cross or any other entity is authorized to make any changes, additions or deletions to the Group Contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done over the signature of an officer of Premera Blue Cross.

Evidence Of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. 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 us.

The Group And You

The Group and the Association Employer are your representatives for all purposes under this plan and not the representatives of Premera Blue Cross. Any action taken by the Group or Association Employer will be binding on you.

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, we'll be 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, at our option:

- Deny the member's claim
- Reduce the amount of benefits provided for the member's claim

- Rescind the member's coverage under this plan (rescind means to cancel coverage back to its effective date, as if it had never existed at all)

Finally, statements that are fraudulent, intentionally false or misleading on any group form required by us, that affect the acceptability of the Group or the risks to be assumed by us, may cause the Group Contract for this plan to be rescinded.

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 Group Contract

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 we provide 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 other 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 or your Group is 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

We have the right to recover amounts we paid that exceed the amount for which we're 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.

In addition, if the contract for this plan is rescinded as described in "Intentionally False Or Misleading Statements," we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, we 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 and in accordance with the law, we may pay 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 our obligation as to payment of benefits.

Venue

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

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, 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 us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in King County, the state of Washington.

Workers' Compensation Insurance

This contract doesn't replace, affect or supplement any state or federal requirement for the Association Employer to provide workers' compensation insurance, employer's liability insurance or other similar insurance. When an employer is required by law to provide or has the option to provide workers' compensation insurance, employer's liability insurance or other similar insurance and doesn't provide such coverage for its employees, the benefits available under this plan won't be provided for illnesses and/or injuries arising out of the course of employment that are or would be covered by such insurance, unless otherwise excepted under the "What's Not Covered?" section in this booklet.

WHAT ARE MY RIGHTS UNDER ERISA?

The Association Employer may have an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). If so, this section of the booklet describes subscriber's rights under ERISA. Please see the Association Employer to find out if this plan is subject to ERISA.

This employee welfare benefit plan is called the "ERISA Plan" in this section. The insured Premera Blue Cross plan described in this booklet is part of the ERISA Plan. For purposes of ERISA only, this plan is considered a separate plan for each Association Employer.

When used in this section, the term "ERISA Plan" refers to the Association Employer's employee welfare benefit plan. The "ERISA Plan administrator" is the Association Employer 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. (Please note that our contract with the Group by itself does not meet all the requirements for an ERISA plan document.) 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 and the Association Employer is required by law to offer COBRA coverage. 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. (Premiera Blue Cross is a fiduciary only with respect to claims processing and payment. However, we do have the discretionary authority to determine eligibility for benefits and to construe the terms used in the portion of the Association Employer's ERISA Plan that we insure.) No one, including your employer, the Group, 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
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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. We have the discretionary authority to determine the terms used in this plan.

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 ("The BlueCard Program") in this booklet.

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

Except as set forth below, the allowable charge will be no greater than the maximum allowance that would have been allowed had the medically necessary covered services been furnished by a provider that has an agreement in effect with the local Blue Cross and/or Blue Shield Licensee (when applicable) or with us (when the provider is in Washington or Alaska or no local Blue Cross and/or Blue Shield allowable charge applies).

When you seek 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 allowable charge (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.

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

Association Employer

The corporation, partnership, proprietorship, government, governmental agency, or other organization, unit or entity that is engaged in business, and is accepted by the Group as a member of the Group.

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.

Custodial Care

Any portion of a service, procedure or supply that, in our judgment, 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

Dental Care Provider

A state-licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this plan are available if professional services are provided by a state-licensed dentist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of his or her license or certification, as allowed by law. This plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

Dentally Necessary

Those covered services which are, in our judgment, determined to meet all of the following requirements. They must be:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan
- Appropriate and consistent with authoritative dental or scientific literature
- Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider
- The least costly of the alternative levels of services which can safely be provided to the member
- Not primarily for research or data accumulation

The fact that the covered services were furnished, prescribed, or approved by a dental care provider does not in itself mean that the services were dentally necessary.

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

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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.

Enrollment Date

For a subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. 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.

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 association that is a party to the Group Contract. The Group is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees.

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 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 Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily

functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

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 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

Plan (also called "This Plan")

The benefits, terms and limitations set forth in the contract between us and the Group, of which this booklet is a part.

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 person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the state of Washington and other such facilities are included as required by state and federal law.

In Washington State, covered licensed or certified categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Acupuncturists (L.Ac.)

- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dental Hygienists (under the supervision of a D.D.S. or D.M.D.)
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following health care facilities and other providers of health care services and supplies will be considered health care providers for the purposes of this plan, as long as they're licensed or certified by the State (unless otherwise stated) that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers

- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

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, in our judgment, 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 Association Employer. Coverage under this plan is established in the subscriber's name.

Subscription Charges

The monthly rates set by us as consideration for the benefits offered in this 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 in the state of Washington, and Premera Blue Cross Blue Shield of Alaska in the state of Alaska.

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 Medco Health Solutions, Inc. At
1-800-626-6080
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