

Seattle Pacific University

Your Choice™ Option 2

1013061

INTRODUCTION

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

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

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.

FOR MORE INFORMATION

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

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

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

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

You can use our Web site to:

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

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HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

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

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

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

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

Participating pharmacies are also available nationwide.

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

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

Important Note: You access network providers in Clark County, Washington and in states other than Washington and Alaska through the BlueCard Program. See "The BlueCard Program" later in this

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booklet for more information about how BlueCard works.

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

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

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

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

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

In-Network Benefits For Non-Network Providers

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

- Emergency care. If you have a "medical emergency" (please see the "Definitions" section in this booklet) this plan provides worldwide coverage.
- Services from certain categories of providers (such as Alcohol Treatment Facilities, blood banks and ambulance companies located in Washington State) to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services

received in Washington or Alaska from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a network provider who doesn't have admitting privileges at a Washington or Alaska network hospital.

- Covered services received from providers located outside the United States, Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

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

BENEFIT LEVEL EXCEPTIONS FOR NON-EMERGENT CARE

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

You, your provider, or the medical facility may ask us for the benefit level exception. However, the request must be made before you get the service or supply. If the request is approved, benefits for covered services and supplies will be provided at the in-network benefit level. Payment of your claim will be based on your eligibility and benefits available at the time you get the service or supply. You'll be responsible for amounts applied toward applicable deductibles, copays, coinsurance, amounts that exceed benefit maximums, amounts above the allowable charge, and charges for non-covered services. If the request is denied, in-network benefits won't be provided.

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

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

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

COPAYMENTS

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

The copays applicable to the "Medical Services" portion of this plan are located under the "What Are

My Copays?" provision in the "What Are My Benefits?" section later in this booklet. Any benefits that are subject to different copays will state those amounts in the benefit.

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

Please refer to the Emergency Room Services benefit under the "What Are My Benefits?" section for more details.

CALENDAR YEAR DEDUCTIBLE

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

Individual Deductible

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

Family Deductible

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

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

What Doesn't Apply To The Calendar Year Deductible?

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

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

COINSURANCE

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

than 100% of the allowable charge.

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

OUT-OF-POCKET MAXIMUM

The "individual out-of-pocket maximum" is the maximum amount, made up of the calendar year deductible and coinsurance that each individual could pay each calendar year for certain covered services and supplies. This plan has separate out-of-pocket maximum limits for network providers and non-network providers.

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 individual out-of-pocket maximums 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. This plan has separate family out-of-pocket maximum limits for network providers and non-network providers.

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 network provider out-of-pocket maximum has been satisfied, benefits subject to that maximum will be provided at 100% of allowable charges for covered services of network providers for the remainder of that calendar year. Once the out-of-pocket maximum for non-network providers has been satisfied, benefits subject to that maximum will be provided at 100% of allowable charges for covered services of non-network providers for the remainder of that calendar year.

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, in our judgment, medically necessary 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 \$100. 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 \$15. These services are also subject to your coinsurance.

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

In addition to office or home visits, this copay also applies to the following services in an office setting: exams, spinal and other manipulations, acupuncture, biofeedback, rehabilitation therapy, neurodevelopmental therapy, and nutritional therapy. This copay doesn't apply to services listed as covered under the Home and Hospice Care

benefit.

WHAT'S MY CALENDAR YEAR DEDUCTIBLE?

Individual Calendar Year Deductible

For each member, this amount is \$100 for covered services from network providers.

For covered services from non-network providers, your calendar year deductible is \$300.

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

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

Family Deductible

The maximum calendar year deductible for your family is \$300 when covered services are received from network providers.

When covered services are received from non-network providers, your family deductible is \$900.

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 40% of allowable charges.

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

- The Ambulance Services benefit
- The Emergency Room Services benefit
- The Transplants benefit
- The Diagnostic Services benefit

- The Diagnostic and Screening Mammography benefit
- The Health Management benefit
- The Prescription Drugs benefit
- The Preventive Medical Care benefit

WHAT'S MY OUT-OF-POCKET MAXIMUM?

Individual Maximum

For care from network providers, your out-of-pocket maximum amount is \$2,100 each calendar year.

For care from non-network providers, your out-of-pocket maximum is \$10,300 each calendar year.

However, benefits that always apply in-network benefits, like Ambulance Services or Emergency Room Services, apply toward the in-network out-of-pocket maximum limit.

Family Maximum

For each family, this amount is \$6,300 per calendar year, for care from network providers.

For care from non-network providers, this amount is \$30,900 for each family 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 \$20,000 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

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 \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. 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 not subject to the office visit copay, but 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 calendar year deductible and 20% 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

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. 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 not subject to the office visit copay, but 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 \$14,000 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.

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

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
- Family and marital counseling, and family and marital psychotherapy, as distinct from

counseling, except when medically necessary to treat the diagnosed substance use disorder or disorders of a member

Contraceptive Management and Sterilization Services

Contraceptive Management and Sterilization Procedures

Consultations

You pay a \$15 copay for each visit in an office setting when you use a network provider. These services are also subject to your coinsurance. 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 not subject to the office visit copay, but 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 \$15 copay for each visit in an office setting. These services are also subject to your coinsurance. However, no more than one copay will be charged for all services that require a copay that are done in a single visit. Services subject to the copay are:

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

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

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

Please Note: If the above contraceptive management or sterilization services and supplies are furnished by a non-network provider or medical

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

Prescription Contraceptives Dispensed By A Pharmacy

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

This benefit doesn't cover:

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

Dental Services

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

Care For Injuries

Professional Visits

The professional visit copay applies to dentist visits to examine the damage done by a dental injury and recommend treatment. You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

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

Dental Treatment

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

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

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

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
 - Extensive restoration, veneers, crowns or splints
 - Periodontal disease or other condition that, 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 the plan's extension criteria. We must receive extension requests within 12 months of the injury date.

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

Inpatient Facility Services

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

Ambulatory Surgical Center Services

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

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

Anesthesiologist Services

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

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

General anesthesia and related facility services for dental procedures are covered when medically

necessary for 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 and coinsurance, if any, 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 any.

If you see a non-network provider, benefits for all diagnostic services are subject to your calendar year deductible, if any, 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 (such as x-rays and EKGs)
- Laboratory services, including routine and preventive
- Pathology tests

Please Note:

- Diagnostic surgeries, including scope insertion procedures, such as 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, if any, 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 \$100 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.

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

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 and community wellness services up to a combined maximum benefit of \$250 per member each calendar year for outpatient health education services and community wellness classes and programs. The health education maximum doesn't apply to health education and training to manage diabetes. Benefits are provided up to a separate maximum benefit of \$250 per member each calendar year for nicotine dependency programs.

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, the plan will 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, the plan will provide benefits as stated above in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

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 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. (Such equipment and supplies are not subject to the benefit maximums stated in the Medical Equipment and Supplies benefit.)

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 14 days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.
Inpatient hospice care is subject to your calendar year deductible and coinsurance when you use a network facility.

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

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

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

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

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

This benefit doesn't cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling

- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

Hospital Inpatient Care

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

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

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

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration
- Medically necessary detoxification services. 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

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. 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 not subject to the office visit copay, but 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.

Covered medical equipment, prosthetics and supplies include:

Medical and Respiratory Equipment

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

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

In cases where an alternative type of equipment is less costly and serves the same medical purpose, the plan will provide benefits only up to the lesser amount.

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

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

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

Benefits for medical supplies, orthotics (other than foot orthotics), and orthopedic appliances are not subject to a benefit maximum.

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.

Benefits for prosthetics are not subject to a benefit maximum.

Foot Orthotics and Therapeutic Shoes

Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting are not subject to a benefit maximum.

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 are subject to the same calendar year deductible, coinsurance or copays, if any, as you would pay for inpatient services and outpatient visits for other covered medical conditions.

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

Benefits are provided for inpatient facility and professional care. As an alternative to inpatient care, this plan covers "psychiatric partial days." These services aren't subject to a calendar year benefit limit.

Outpatient Therapeutic Visits

Benefits are provided for outpatient office or home therapeutic visits. Also covered under this benefit are biofeedback services for generalized anxiety disorder when provided by a qualified provider. These services aren't subject to a calendar year benefit limit.

"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

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. 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 not subject to your office visit copay, but 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.

Newborn Care

Newborn children are covered automatically for the first 4 days from birth when the mother is eligible to receive obstetrical care benefits under this plan. To continue benefits beyond the 4-day 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 4 days. 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

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. 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 not subject to the office visit copay, but 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

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. 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 not subject to the office visit copay, but 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. These services aren'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 the subscriber or enrolled spouse. Obstetrical care benefits aren't covered for dependent children. However, complications of pregnancy are covered on the same basis as any other illness for the subscriber, enrolled spouse, or enrolled dependent child.

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.

Orthognathic Surgery (Jaw Augmentation Or Reduction)

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 you use a network provider.

Outpatient Surgical Facility Services

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

Outpatient Professional Visits

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

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

Other Professional Services

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

Please Note: If services and supplies are furnished by a non-network provider or medical facility, benefits for orthognathic surgery 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 medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw

(orthognathic and/or maxillofacial surgery) are provided. Covered services include repair of a dependent child's congenital anomaly. Orthognathic surgery isn't subject to a calendar year benefit limit. These procedures are not covered under other benefits of this plan.

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 for routine and preventive services performed on an outpatient basis are provided up to a combined maximum benefit of \$750 per member each calendar year. Your calendar year deductible and coinsurance do not apply when services are received from a network provider.

Immunization benefits are subject to the calendar year limit for preventive care services specified above.

Routine or Preventive Exams

Benefits for exams are covered at 100% of allowable charges when you see a network provider.

Please Note: If you see a non-network provider, preventive medical 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.

Immunizations

Benefits for immunizations are covered at 100% of allowable charges and not subject to your calendar year deductible when services are received from network or non-network providers.

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 (hearing exams are covered under the Hearing Exams Benefit)
- 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.

Outpatient Professional Exams and Visits

You pay a \$15 copay per visit in a home or office setting when you use a network provider. These services are also subject to your coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

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

Other Professional Services

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

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

Benefits are also provided for the following professional services when provided by a qualified provider:

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see "Definitions")

- Diabetic foot care
- Repair of a dependent child's congenital anomaly

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

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

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

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

For diagnosis and treatment of psychiatric conditions benefit information, please see the Mental Health Care benefit.

For diagnosis and treatment of temporomandibular joint (TMJ) disorders benefit information, please see the Temporomandibular Joint (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 24 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

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

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

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

A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one

visit, unless provided by different health care providers.

Chronic Pain Care

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

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

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

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

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 \$15 copay per visit in a home or office setting when you use a network provider. These services are also subject to your coinsurance. 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

You pay a \$15 copay per visit in an office setting when you use a network provider. These services are also subject to your coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

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

Other Outpatient Professional Services

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

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 plan sponsored by the Group for 12 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 by a medical plan sponsored by the Group since birth
- A congenital anomaly of a child who's been covered by a medical plan sponsored by the Group 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

You pay a \$15 copay per visit in an office setting to a network provider or an approved transplant provider. These services are also subject to your coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

When a professional visit isn't provided in an office setting, benefits are not subject to the office visit copay, but 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 the plan's 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 the plan's criteria for coverage are:

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

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

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

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

- 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 12-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

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 copay
Preferred List Brand.....	\$25 copay
Name Drugs	
Non-Preferred List Brand.....	\$40 copay
Name Drugs	

Dispensing Limit

Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. 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 copay
Preferred List Brand.....	\$50 copay
Name Drugs	
Non-Preferred List Brand.....	\$80 copay
Name Drugs	

Dispensing Limit

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

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 will 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 would 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, the plan will 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 the allowable charge. This benefit applies to all prescriptions filled by a non-participating pharmacy, including those filled via mail or other home delivery.

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

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

Questions and Answers About Your Pharmacy Benefits

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

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

The plan encourages the use of appropriate "generic drugs" (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. If a generic equivalent isn't manufactured, the applicable brand name copay or coinsurance will apply. You may request a brand name drug instead of a generic, but if a generic equivalent is available and substitution is allowed by the prescriber, you'll be required to pay the applicable brand name drug copay or coinsurance. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

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

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

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

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

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 only be changed at the sole discretion of the Group. 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 the participating pharmacy network. Your benefit covers prescription drugs dispensed from a non-participating pharmacy, but at a higher out-of-pocket cost to you as explained above.

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

Specialty Pharmacy Program "Specialty drugs" are drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis or multiple sclerosis. The plan makes use of our contracted specialty pharmacies, which 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, the plan may limit benefits to a specific dispensed days' supply, drug, or drug dosage appropriate for a usual course of treatment. The plan 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, 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 are all taken into consideration.

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.

HEARING EXAMS

You pay a \$15 copay per visit when you use a network provider for routine hearing exams. These services are also subject to your coinsurance.

If you see a non-network provider, benefits for routine hearing exams 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 one routine hearing examination (or screening) per member each calendar year.

Hearing exam services include:

- Examination of the inner and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- Hearing testing services, including the use of calibrated equipment.

The Hearing Exams benefit doesn't cover hearing hardware or fitting examinations for hearing hardware.

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 and Seattle Pacific University's 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. When you receive care from doctors, 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 the plan's sole discretion. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

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

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 12-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, the plan won't provide benefits for the following:

Benefits From Other Sources

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

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Boat coverage
- Commercial liability coverage
- Homeowner policy
- School or athletic policy
- Other type of liability or insurance coverage
- Worker's Compensation or similar coverage
- Any excess insurance coverage

Benefits That Have Been Exhausted

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

Biofeedback Services

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

Caffeine Or Nicotine Dependency

Treatment of caffeine or 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 Dental Services (please see the "Medical Services" section under "What Are My Benefits?")

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

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:

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

Hair Loss

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

Hearing 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

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"

Pregnancy Of Dependent Children

Any care connected with a dependent child's pregnancy, except care furnished for the treatment of a complication of pregnancy.

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
 - Preventive Medical 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

Vision Hardware

Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies. Also not covered are 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 Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

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

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

Definitions Applicable To Coordination Of Benefits

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under any of the medical plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the

reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.

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

or employee benefit organization plans

- Government programs that provide benefits for their own civilian employees or their dependents

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

Effect On Benefits

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

Primary And Secondary Rules

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

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

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

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

Dependent Children Unless a court decree states

otherwise, the rules below apply:

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

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

Right Of Recovery/Facility Of Payment

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

Coordinating Benefits With Medicare

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

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

SUBROGATION AND REIMBURSEMENT

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

Definitions The following terms have specific meanings in this section:

- **Subrogation** means we may collect, on behalf of the plan, directly from third parties to the extent the plan has paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated to repay any monies advanced by the plan from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that the plan has to the monies advanced under your plan. Because the plan has paid for your illness or injuries, the plan is entitled to recover those expenses.

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

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

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

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

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

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

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage. The Group has 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:

- Employees must be classified by the Group as a regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group's payroll system, and reported by the Group for Social Security purposes. The employee must also regularly work a minimum nine month work schedule and 20 hours per week
- Be a retired employee who meets all the requirements below. The employee:
 - Has attained age 60 to 64
 - Has at least 10 or more years of credited service with the Group.
 - Retirees must be enrolled in the Group's plan,

prior to termination of employment.

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated.
- An eligible child who receives more than half of his/her support from the subscriber and is claimed as a dependent on the subscriber's tax return. (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 30 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 **latest** of the applicable dates below.

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

- The employee's date of hire
- The date the employee enters a class of employees to which the Group offers coverage under this plan

If we don't receive the enrollment application within 30 days of the date you became eligible, none of the dates above apply. Please see "Open Enrollment" and "Special Enrollment" later in this section.

Waivers of Coverage

If an employee wants to decline coverage when first eligible, the Group requires the employee to sign a written waiver stating the reason for declining coverage under this plan. Unless the employee qualifies under "Special Enrollment," the employee then loses the right to enroll in this plan for two years after the date the waiver was signed. The employee can then enroll during the first open enrollment period after the two-year period ends. Please see "Special Enrollment" and "Open 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 30 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 30 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 4 days from birth when the mother is eligible to receive obstetrical care benefits under this plan. To extend the child's coverage beyond the 4 day 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 30 days following birth. Coverage becomes effective from the date of birth. If we don't receive the enrollment application within 30 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 30 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 30 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 30 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 30 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 30 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid or the state child support enforcement agency. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

If the subscriber is not enrolled on the date of the order, the subscriber will be allowed to enroll in order to enroll the child. However, no other dependents have the right to enroll.

SPECIAL ENROLLMENT - ELIGIBLE EMPLOYEES

Voluntary Waiver of Coverage

If you didn't enroll when you were first eligible because of a required personal premium contribution and your position with the employer has

changed such that you are now eligible without said required personal premium contribution, you may enroll within 30 days of the change in the employees position.

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 Group's next open enrollment period. Please see "Waivers of Coverage" earlier in this section. An open enrollment period occurs once a year unless otherwise determined by the group. During this period, eligible employees and their dependents can enroll for coverage under this plan. Eligible retirees as defined in the "Who Is Eligible For Coverage?" section can also enroll their eligible dependents for coverage under this plan during open enrollment.

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

CHANGES IN COVERAGE

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

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

PLAN TRANSFERS

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

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

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

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

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

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.

PLAN TERMINATION

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

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue for a dependent child who can't support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child 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

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to 6 months when the employer grants the subscriber a medical leave of absence. Periods of medical and personal leave of absence count toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993 (Public Law 1033). Refer to the Employer's Benefits Handbook for information regarding personal leaves of absence or additional details.

LABOR DISPUTE

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

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

COBRA - ELIGIBLE EMPLOYEES

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

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

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

Continuation Coverage For Retiree Subscriber Dependents

Retiree subscriber dependents may be eligible for continued coverage because of:

- Divorce or legal separation from the retiree subscriber
- The retiree subscriber's entitlement to Medicare Benefits
- Loss of dependent child status

These individuals will receive coverage for the same length of time as they would have received under COBRA.

Qualifying Events and Length of Coverage

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

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:

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

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

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

- **The subscriber dies.**
- **The subscriber and spouse legally separate or divorce.**
- **The subscriber becomes entitled to Medicare.**
- **A child loses eligibility for dependent coverage.**

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The

extended period will end no later than 36 months from the date of the first qualifying event.

- **The Group must offer the retired subscriber and covered dependents an election to continue their coverage if that coverage is lost because the Group filed for bankruptcy.**

Coverage is considered lost due to this qualifying event if the retiree group coverage was substantially eliminated at any time between 1 year before the bankruptcy proceeding commenced and 1 year after it commenced.

If the above event occurs, the retiree subscriber may continue coverage for up to the rest of his or her life. The retiree subscriber's covered spouse and children may continue for up to 36 months after the retiree subscriber's death or until they lose eligibility as dependents, whichever occurs first. (If the retiree subscriber died before the bankruptcy, but his or her spouse is still covered under this plan when the bankruptcy filing occurred, that surviving spouse may continue coverage for up to the rest of his or her life.)

Conditions of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

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

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please note: Determinations that a qualified member is disabled must be given to the Group before**

the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice. Please include a copy of the determination with your notice to the Group.

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

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

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

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

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

You Must Enroll And Pay On Time

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

you believe this may apply to you.

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

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 Group will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.

- You must send your first monthly payment to the Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly payments must be paid to the Group 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" earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

occurs:

- The applicable continuation period expires.
- The next monthly 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 Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.
- You become covered under another group health care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage.
(This doesn't apply to retirees and their dependents who are continuing retiree coverage as a result of a bankruptcy filing.)
- The Group ceases to offer group health care coverage to any employee.

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" in the "When Will My Coverage End?" section.

If You Have Questions

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

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than rescission.

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
- 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 4-day 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 Premera Blue Cross's Conversion plans when your coverage under this plan ends. Conversion plans are individual plans insured by Premera Blue Cross, and they 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 the Group 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

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

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

Step 1

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

Step 2

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

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

The plan won't provide benefits for claims we receive after the later of these 2 dates, nor will the plan provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

Special Notice About Claims Procedure

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

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

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

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

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

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

WHAT IF I HAVE A QUESTION OR AN APPEAL?

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 the 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 to reconsider 1) a decision on a complaint, or 2) a 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.

Appeals Process

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

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

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

If you don't agree with the decision reached in our Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. **You must make your request for a Level II review no more than 60 calendar days after the date you receive our Level I decision.** This time limit may be extended in the event 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 panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. The panel will give you a decision within 30 calendar days of the date we receive your Level II request.

You also have the right to file suit in federal court if you're not satisfied with the outcome of the Level II appeal.

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 the Level II decision within the time limit stated. We must

receive your request for independent review within 60 calendar days of the date that the appeal decision was due.

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 the Group will pay the charges of the IRO. The IRO will give you its decision in writing. We'll implement the IRO's determination promptly.

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Member Cooperation

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

Evidence Of Medical Necessity

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

Intentionally False Or Misleading Statements

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

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

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

Notice Of Information Use And Disclosure

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

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

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

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

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

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

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

Notice Of Other Coverage

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

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

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

Notices

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

Right Of Recovery

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

Right To And Payment Of Benefits

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

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

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

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

Venue

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

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

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

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

Workers' Compensation Insurance

This contract doesn't replace, affect or supplement any state or federal requirement for the Group 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.

ERISA PLAN DESCRIPTION

This employee welfare benefit plan is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). This employee welfare benefit plan is called the "ERISA Plan" in this section. ERISA gives subscribers and dependents the right to a summary describing the ERISA Plan. The ERISA Plan details below, together with the information contained throughout this benefit booklet, make up the "summary plan description" required by ERISA.

Name Of Plan

Seattle Pacific University Health & Welfare Plan

Name And Address Of Employer Or Plan Sponsor

Seattle Pacific University
3307 Third Avenue West
Seattle, WA 98119

Employer Identification Number "EIN"

91-0565553

Plan Number

507

Type Of Plan

Self-funded employee welfare benefit plan that is a group health plan. The ERISA Plan provides hospital and medical benefits.

Type Of Administration

Third-party administration by Premera Blue Cross under the terms and conditions of its administrative services contract with the Group. We do not insure this plan.

Name, Address, And Telephone Number Of ERISA Plan Administrator

Seattle Pacific University
Office of Human Resources, Suite 302
3307 Third Avenue West
Seattle, WA 98119
206-281-2809

Agent For Service Of Legal Process

Seattle Pacific University
3307 Third Avenue West
Seattle, WA 98119

Eligibility To Participate In The Plan

Employees and their dependents are eligible for the benefits of the plan when they meet the eligibility requirements in this booklet, are enrolled as described in this booklet, and if they continue to pay all required monthly charges for coverage to the Group as required by the Group.

Benefits

The benefit booklet tells you the terms and limitations of each benefit of this plan. You may have lower out-of-pocket costs if you use providers that have signed contracts with us. This booklet explains the provider network(s), when applicable. It also tells how benefits are affected if members don't use these providers. Coverage for emergency care and care you receive outside Washington and Alaska are also described. The benefit sections of this booklet also explain what part of the cost of covered health care that you must pay.

Disqualification, Ineligibility Or Denial, Loss, Forfeiture, Or Suspension Of Any Benefits

This booklet describes circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, reduction, offset or recovery of any benefits for members.

Source Of Contributions

The employer pays 100% of the cost of the employee's coverage. The employees pays 100% of the cost of their eligible dependent's coverage. Self-payments are also permitted; please see the "How Do I Continue Coverage?" section in this booklet.

Plan Changes and Termination

The "Plan Termination" and "Changes In Coverage" portions of this booklet describe the circumstances when this plan may be changed or terminated. No

rights are vested under the ERISA Plan. The Group reserves the right to change or terminate its ERISA Plan in whole or in part, at any time, with no liability.

The Group will tell employees if its ERISA Plan is changed or terminated. If the ERISA Plan were to be terminated, members would have a right to benefits only for covered services received before the ERISA Plan's end date.

ERISA Plan Year

The ERISA Plan year ends on each June 30th.

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. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods

of coverage for pre-existing conditions under your group health plan, (if this plan has such an exclusionary period) when you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, if you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. (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 Group’s ERISA Plan that we insure.) No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan’s money, or if you’re

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

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

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

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

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

DEFINITIONS

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

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**

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, for your normal share of the claims costs (see the "What Are My Benefits?" section for further detail).

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

Ambulatory Surgical Center

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

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures
- It doesn't provide inpatient services or accommodations

Calendar Year

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

Chemical Dependency

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

- The user exhibits a loss of self-control over the

amount and circumstances of use

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

Community Mental Health Agency

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

Complication Of Pregnancy

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

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

Congenital Anomaly

A marked difference, from the normal structure of a body part, that's physically evident at birth.

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

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

Seattle Pacific University, the entity that sponsors this self-funded plan.

Hospital

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

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

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

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

Illness

A sickness, disease, medical condition or pregnancy.

Injury

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

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical 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 Group's self-funded plan described in this booklet.

Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
 - **The American Hospital Formulary Service-Drug Information**
 - **The American Medical Association Drug Evaluation**
 - **The United States Pharmacopoeia-Drug Information**
- Other authoritative compendia as identified

from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner

- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Provider

A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

Psychiatric Condition

A condition listed in the **Diagnostic and Statistical Manual (DSM) IV** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

Retiree

Enrolled employees who are retiring from the Group between the ages of 60 to 64 with at least 10 years of service credit.

Retiree Subscriber

An enrolled retired employee of the Group. Coverage under this plan is established in the retiree subscriber's name.

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 or retiree of the Group except where otherwise specified in this document. Coverage under this plan is established in the subscriber's name.

Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

We, Us and Our

Means Premera Blue Cross.

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To
Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

Contact 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 An Appeal

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

BlueCard

1-800-810-BLUE(2583)

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www.premera.com