Regence BlueShield

Selections® Plan

A Quick and Easy Guide to Benefits

Regence

Selections® 100/60/15 or 30

City of Tacoma

- Non-Commissioned Active Employees
- TERS (Early Retirees)
- LEOFF I – Fire Department Active Dependents
- LEOFF I – Fire Department Retiree Dependents
- LEOFF II - Fire Department
- LEOFF II - Fire Department Retirees
- LEOFF I - Police Department Active Dependents
- LEOFF I - Police Department Retiree Dependents
- LEOFF II – Police Department Local 26
- LEOFF II – Police Department Local 26 Retirees
- LEOFF II – Police Department Local 6
- LEOFF II – Police Department Local 6 Retirees

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WELCOME TO A DIFFERENT KIND OF HEALTH PLAN

Welcome to Selections. As you'll soon discover, this health plan isn't like health plans used to be.

For starters, it can help reduce the amount of out-of-pocket money you have to spend on health care. It also provides you with your own medical "care coordinator" to make sure you always get the most appropriate care.

All this is made possible by a partnership that includes your employer, your health care provider, Regence BlueShield, and you. Working together, we can reduce unnecessary medical expenses, so you can have care that's both appropriate and affordable.

As a member of Selections, you'll receive this care from a carefully selected network of doctors, hospitals, and other health care providers.

This Benefits Guide explains how that works, answers questions about your coverage, defines the special terms used (please see the "Definitions" section of this brochure), and instructs you on how to use the plan to best meet your needs. Please read it carefully to become familiar with all of the advantages of your Selections plan.

If you have any questions about your Selections benefits, please call the number listed in the Customer Service Directory.

In this brochure, Regence BlueShield is referred to as the "Company."

Regence BlueShield has contracted with the Group to provide administrative services, including claims processing, and does not assume any financial risk or obligation with respect to claims.

HOW DOES SELECTIONS WORK?

Selections is based on the concept of a Personal Care Provider or "PCP." A PCP isn't only a highly qualified medical practitioner. They also serve as your medical "coach." In other words, it's your PCP's job to make sure you get the most appropriate medical care, and to monitor the care you receive from specialists, hospitals and other providers. (To find out how to select a PCP, see the section entitled "How Do I Choose A PCP?")

You'll usually receive a higher level of benefits (and pay lower out-of-pocket costs) when your PCP coordinates your care. On the other hand, you can go outside the Selections network to a Selections, Preferred Plan, or participating provider in the "extended network." Except for some services (where you're allowed to make an appointment directly with a Selections, Preferred Plan, or participating provider), you'll receive a lower level of benefits and you'll pay more out-of-pocket costs when you go outside the Selections network.

Either way, the choice is completely up to you each and every time you seek medical care.

This diagram gives you an overview of how to get medical care, both from the Selections network and from the extended network. Keep these points in mind when getting care:

- All care must be coordinated by your Personal Care Provider for you to qualify for the highest level of benefits. The only exceptions are emergency services and the "self-referral benefits" described in the diagram.
- You have the greatest freedom of provider choice within what is known as the "extended network," but your benefits will usually be paid at a lower level, so you'll have greater out-of-pocket expenses.

You'll find detailed information about each of the steps throughout this brochure. So please read it carefully to familiarize yourself with all of the provisions of your plan—including any limitations or exclusions.

To Get the Highest Level or Selections Network Benefits (You pay less out-of-pocket)			**To Get Partial or Extended Network Benefits** (You pay more out-of-pocket)
• See your PCP. Your PCP may refer you to a specialist or hospital.	**OR**	Self-refer for: • Routine vision and hearing exams* • Repair of Teeth* • Smoking Cessation* • Covered services of a chiropractor* • Covered women's health care services (This provider may refer you to a specialist or hospital.)*	Self-refer to any Selections, Preferred Plan, or participating provider who is not your PCP.
* See "Benefits" section for more details. This chart applies only to care delivered inside your service area. See page 11 for information on benefits *outside* your service area.			

HOW DO I CHOOSE A PCP?

Your Selections plan allows you to choose a different Personal Care Provider (PCP) for each member of your family. And you can select your PCP(s) from an extensive list of providers such as general practitioners, family practitioners, pediatricians, internal medicine physicians, registered nurses, and naturopaths.

Include the name and identification number of each PCP you select when you complete your application form. Once you have been accepted for coverage, we will send you written confirmation of your selected PCP(s).

You may change your PCP at any time by calling us or submitting an Employee Enrollment & Change Form through your employer. The change will become effective the day we receive it.

Please note that choosing a Personal Care Provider is not a requirement of your Selections plan, but your benefits will generally be lower if you do not select a PCP to coordinate your care. Other requirements also apply. For more information, see the section entitled “What Do I Do When I Need Care?”

WHAT DO I NEED TO DO BEFORE I GET CARE?

Your Selections plan includes a health management program designed to encourage you to be aware of—and involved in—decisions about the most appropriate level of medical care.

Please read the following sections on second surgical opinions and preadmission approval carefully. It is important that you follow these procedures in order to get full use of your benefit coverage. Otherwise your benefits could be significantly reduced. Remember, too, that benefits for these procedures are subject to any annual deductible, and all other provisions of this plan as described in this brochure.

VOLUNTARY SECOND SURGICAL OPINION

If you choose to have a voluntary second surgical opinion before having surgery, the physician's services and any related x-ray and laboratory services for the second opinion will be provided in full, not subject to any deductible or copay provisions of this plan, when performed by the physician referred to you as described below.

Your Selections, Preferred Plan, or participating physician can handle obtaining a second opinion referral by contacting the Company at the number listed in the Customer Service Directory. The Company will furnish the names of physicians from whom the second opinion may be obtained. The second opinion must be obtained from a physician referred to the member by the Company, and who is not the physician who will perform the surgery.

You may use one of the physicians referred by the Company to take advantage of the copay and deductible waiver, but if you choose not to use one of the physicians referred by the Company, the benefit will still be paid under this plan, but at the Professional Services payment level. If you do not follow the procedures for obtaining a second surgical opinion, benefits will be paid at the Professional Services payment level, and will be subject to any deductible or copays of your plan.

A third opinion will also be covered if the first two opinions do not agree, but no additional opinions will be covered. Once you receive the second opinion, even if the physicians do not agree, the decision to have the surgery will rest with you.

If you have any questions on the voluntary second surgical opinion process, you may call the phone number listed in the Customer Service Directory.

PREADMISSION APPROVAL

The preadmission approval requirements of this section will apply only to the member who seeks an inpatient admission from providers outside the service area that have not contracted with a Blue Cross and/or Blue Shield plan. All medical and surgical care received outside the service area that is not a medical emergency must be obtained in a setting other than inpatient, unless the Company determines that inpatient care is medically necessary.

If you are using a provider outside the service area who has not contracted with a Blue Cross and/or Blue Shield plan in that area, you must have your provider contact the Company prior to any inpatient admission that is not a medical emergency by submitting a "Preadmission Review Request" form (available from the Company at the address given in the Customer Service Directory) to the Company at least 10 days before your admission date; or you may have your provider contact the Company by telephone at the number listed in the Customer Service Directory.

The Company will evaluate the information provided by your provider to determine in advance whether inpatient care is medically necessary. A new approval should be obtained for each admission or readmission.

It is not necessary to request preadmission approval for emergency services; maternity admissions when you or your spouse is in labor or scheduled for a cesarean section or labor induction (however, notice of such admissions should be given to the Company within 48 hours or by the first working day after the admission); treatment in an outpatient facility or provider's office; or admissions to hospitals outside of the United States or hospitals within United States territories.

If the preadmission approval is not requested and the Company determines that an inpatient level of care is not medically necessary, benefits for the inpatient care, including any related physician's services, will be provided at one-half of the Selections network payment level for Professional Services or the amount that would have been paid had the services been received in an appropriate alternative setting, whichever is greater. You will be responsible to pay the additional charges. If the inpatient level of care is determined to be medically necessary, the regular benefits of this plan will be provided.

If you or your provider have any questions on the preadmission approval process, please call the phone number listed in the Customer Service Directory.

WHAT DO I DO WHEN I NEED CARE?

Your Selections plan is designed to be as simple to use as possible. When you need medical care, just follow these steps. That way, you'll be assured of receiving the Selections network level of benefits.

Be sure to present your Selections identification card to your provider before receiving care.

CARE WITHIN THE SELECTIONS SERVICE AREA

Within the Selections service area, you can choose either of two benefit levels: Selections network benefits (most of which are coordinated through your PCP), or extended network benefits. Each time you need medical care you are free to decide which provider you want to use. Your choice will determine the level of benefits you receive. The level you choose will affect how your benefits will be paid. The benefits of this plan will be provided for any service performed by a registered nurse acting within the scope of the license if this plan would provide benefits for the services when performed by a physician. You will be reimbursed up to the percentage of the allowed amount as specified for other physician services. No benefits will be provided unless you are under the care of one of the providers specified below.

SELECTIONS NETWORK BENEFITS

The Selections network consists of physicians, hospitals and other providers who have demonstrated a commitment to the effective use of health care resources. To receive care at the highest payment level, follow these four steps:

1. Select a Personal Care Provider for yourself and each member of your family when you complete your application. Feel free to contact us if you need help finding a Personal Care Provider who can manage your care.
2. When you need care, contact your Personal Care Provider first. He or she will treat you or determine if you need to seek more specialized care, and refer you to a specialist, if necessary. If you have a complex or serious medical or psychiatric condition, a standing referral may be issued for an extended period of time, subject to the limitations and provisions of this plan. If there is no appropriate Selections provider to treat you, your PCP also has the authority to refer you to other types of providers. In those limited circumstances as specifically stated in the "Benefits" section of this brochure, you may refer yourself directly to a

provider other than the Personal Care Provider and receive the Selections network payment level. If you self-refer to a provider, except as specifically allowed in the "Benefits" section, the extended network benefit payment level will be provided.

3. If you need to be admitted as an inpatient for care at a hospital or clinic, your Personal Care Provider will handle all arrangements with the facility.
4. Some Personal Care Providers are part of a medical group that use specific specialists, hospitals, and other facilities. If you select one of these as your Personal Care Provider, he/she will primarily refer you to providers within that medical group when you need specialty care. Please contact your Personal Care Provider if you have questions about their specific referral practices.

EXTENDED NETWORK BENEFITS

The extended network benefits are available when you use a Preferred Plan or participating provider, or you use a Selections provider but you have not selected or had your care coordinated through a Personal Care Provider, except for specified self-referral benefits. You will also receive extended network benefits when you use a Personal Care Provider without first informing the Company who your PCP is. Extended network benefits are described elsewhere in this brochure.

EMERGENCY CARE

If you have a medical emergency, go to the nearest appropriate facility. In an emergency, treatment by a provider that is not normally covered under this plan will be recognized for 24 hours, or as long as it reasonably takes to come under the care of a Selections, Preferred Plan, or participating provider. Benefits will be based on the recognized provider's actual charge for the service where those charges are reasonable and are not increased on the basis of the coverage of this plan. *If you are admitted to a hospital outside the service area, you must call us within 24 hours to continue to receive the highest level of benefits.* Benefits will be provided at the level specified in the Payment Schedule for Selections network benefits.

Please refer to the "Definitions" section to see how a medical emergency is defined for this plan.

HEALTH CARE RESPONSIBILITY

All health care services are provided by facilities and professionals who are neither employees nor agents of the Company. The fact that

a provider is listed in the Company's provider directory does not mean the provider is the Company's employee or agent. Providers are responsible for the quality of care they render.

CARE OUTSIDE THE SERVICE AREA

Outside the Selections service area, benefits will be provided for care received from a Preferred Plan, participating, or recognized provider (see the "Definitions" section) Payment will be based on the allowed amount at the Selections Network Benefits level specified in the Payment Schedule.

If you live inside the service area and are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours (or the next business day) to receive full plan benefits.

You must also agree to comply with the Company's managed care guidelines, which may require you to move under the care of a Selections provider in the service area as soon as we feel it is medically feasible. If you meet all requirements, inpatient benefits will be provided at the level of the Selections network.

Remember to present your identification card when consulting a provider or receiving treatment at a hospital. If your care is received within the service area of a local Blue Cross and/or Blue Shield plan, choosing a participating provider with that local plan can decrease your out-of-pocket expenses. By using your identification card, participating providers can submit your claims to the local Blue Cross and/or Blue Shield plan.

See the "How Do I File A Claim?" section of this brochure for information on submitting claims.

WHEN AM I ELIGIBLE FOR COVERAGE?

EMPLOYEE ELIGIBILITY

All active employees of the City of Tacoma on the first working day of each month, will be eligible for coverage paid by the City of Tacoma for that month. A complete list of eligible employees is located in the Compensation and Personnel Rules provided by the Human Resource Department.

In this brochure, the employee is referred to as the "subscriber."

RETIREE ELIGIBILITY

At age 65, employees are eligible for Medicare coverage and are no longer eligible for benefits under the City of Tacoma group plan with Regence BlueShield. An employee whose birthday is on or after the second day of the month will be entitled to Medicare coverage effective the first day of that month. For an employee whose birthday is the first of the month, Medicare coverage will be effective from the first day of the previous month. Medicare is the basic coverage plan for employees age 65 and over. Employees may purchase Supplement to Medicare coverage through Regence BlueShield or another carrier.

LEOFF I DEPENDENT ELIGIBILITY

The City of Tacoma Police and Fire Pension Boards provide LEOFF I retirees the option of purchasing group medical coverage for eligible dependents. Such coverage will be available through Regence BlueShield at the same group rates offered to the City of Tacoma. LEOFF I retirees may purchase coverage for dependents following these conditions:

If your dependent is under age 65: Your eligible spouse under age 65 and eligible children may be enrolled at your retirement. Thereafter, your eligible spouse and eligible children may not enroll for coverage until the next open enrollment period, conducted in January. Open enrollment requests and inquiries should be directed to the Police and Fire Pension Office.

If your dependent is over age 65: If a spouse over age 65 remains on his or her employer's medical plan, he or she will be eligible for continuous enrollment after the spouse ceases employment, regardless of age. Spouses who leave the plan after reaching age 65 will not be eligible for reenrollment.

DEPENDENT ELIGIBILITY

Eligible dependents include:

- The subscriber's lawful spouse.
- The domestic partner of the subscriber. If all requirements are met, as stated in the signed "Affidavit of Qualifying Domestic Partnership," all plan provisions stated as applicable to a spouse will also be applicable to a domestic partner. For the purpose of this plan, the use of the term "marriage" will also be applicable to a domestic partnership.
- A natural child, adopted child, a child legally placed with the subscriber for adoption including a child for whom the subscriber has assumed a total or partial legal obligation for support in anticipation of adoption, a stepchild, or a child for whom the subscriber is the legal guardian (the subscriber will need to provide a court order showing legal guardianship). In addition, a child of the subscriber will be eligible for coverage under this plan when required by a court order. A child must be under age 25 and unmarried to be eligible for coverage under this plan. Children who are incapacitated due to developmental disability or physical handicap and chiefly dependent upon the subscriber, spouse, or non-covered legal parent for support and maintenance are also eligible for benefits, provided the dependent child was covered on the day before the 25th birthday and the incapacity occurred prior to the 25th birthday. Benefits will be provided for the duration of the incapacity unless coverage terminates. If the incapacitated child's coverage ends for any reason after the 25th birthday, the child will not be eligible for coverage under this Dependent Eligibility provision.

APPLICATION FOR COVERAGE

To become covered under this plan, you must first complete an application for yourself and each family member you wish to cover. For employees, coverage begins on the first day of the next month after your application has been received by the Company and you have completed any probationary period required by your employer. For dependents who are eligible and are included on the subscriber's application, coverage begins on the subscriber's effective date.

If you or your dependent is not enrolled for coverage when initially eligible, coverage will not be available until the next open enrollment period, except when required by court order.

If you declined enrollment in writing, for you or your dependents, due to other health coverage, you and any eligible dependents may apply for coverage under this plan, or any other plan offered by the

group, prior to the next anniversary date if the Company receives your application for coverage (a) within 30 days of exhaustion of COBRA continuation coverage, loss of eligibility for the prior health coverage, or loss of an employer's contribution to the rate of the prior health coverage or (b) within 60 days of the date the Washington State Department of Social and Health Services (DSHS) makes a determination that it is cost-effective for eligible dependent(s) to have coverage under the plan. Coverage will begin on the first day of the month after the Company has received the application. If you acquire a dependent either through adoption, placement for adoption, birth of a child, or marriage, you and your dependents may apply for coverage under this plan or any other plan offered by the group, prior to the next anniversary date. The Company must receive your application within 31 days of marriage, or within 60 days of birth, placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. Coverage for you and your dependents will begin retroactive to either the date of birth of a natural newborn, the date of placement of an adoptive child, the date of assumption of total or partial legal obligation for support of a child in anticipation of adoption, or in the case of marriage, on the first day of the month after the Company has received the application.

Please submit a new Employee Enrollment & Change Form to your employer if there is any change in your family's eligibility. Forms are available through your employer.

NEWBORN AND ADOPTED CHILDREN

For the subscriber's natural newborn child, coverage will be retroactive to the date of birth provided the Company receives the subscriber's application for the new dependent's coverage within 60 days following birth. For the subscriber's adopted child, coverage will be retroactive to the date of placement for adoption or the date the subscriber assumed total or partial legal obligation for the child's support in anticipation of adoption if the Company receives the subscriber's application for the new dependent's coverage within 60 days following placement or the subscriber's assumption of legal obligation for the child's support. If your group's Agreement does not require a rate payment for the natural newborn or adoptive child, you do not have to complete an application for the child. However, for both newborns and adopted children, the Company should receive applications within 31 days to prevent delays in claims processing.

FALSE STATEMENTS

If the member or anyone acting on their behalf makes a false statement in the application or eligibility records or withholds information with intent to deceive or affect the acceptance of the application or the risks assumed by the Company, or otherwise misleads the Company into providing benefits it would not otherwise have provided, the Company shall be entitled to recover its damages from the member, from the group, from any other person responsible for misleading the Company, and from the person for whom the benefits were provided. In addition, the Company may retroactively terminate coverage under this Agreement for a member who commits fraud or material misrepresentation in connection with obtaining coverage or benefits such as providing false or misleading information on a claim. Coverage will not be offered to an employee of the group or the employee's dependents whose coverage was previously terminated for fraud or material misrepresentation or was not accepted for the same reasons.

WHAT DO I HAVE TO PAY FOR?

This section includes information on how your plan covers the services and supplies listed in the following “Benefits” section. Each of the key factors in this section (copays, deductible, coinsurance amounts listed in the Payment Schedule, and the stoploss amounts) affects how your claims will be paid.

Selections Network Benefits: To receive the Selections network benefits, you must use or have your care coordinated through your Personal Care Provider.

Extended Network Benefits: To receive the extended network benefits, you must use a Selections, Preferred Plan, or participating provider.

COPAYS

Each covered person will be required to pay the dollar amounts specified below.

A $15 copay will be applied to Selections network providers and a $30 copay will be applied to extended network providers for each outpatient professional service (except lab and x-ray services) performed in the office, home, hospital outpatient department or other facility. Copays apply to all outpatient professional services as noted in the “Benefits” section.

A $150 copay will be applied to each new inpatient admission to any extended network inpatient facility. This copay does not apply to maternity admissions or skilled nursing facilities and will be waived if readmitted within 90 days for the same condition.

You will also be responsible to pay a $75 copay for each visit to an outpatient surgical center or a hospital emergency room for illness, injury or surgery. This amount will be waived for diagnostic x-ray and laboratory services, chemotherapy and radium therapy, and if you are directly admitted to the hospital as an inpatient.

Copays cannot be used to satisfy your annual deductible and will not accumulate toward your stoploss limits.

DEDUCTIBLE - Required for Extended Network Benefits (including care outside the service area)

The deductible is the cost of **covered** medical expenses outside the Selections network benefits that you must reach and are responsible

to pay before your extended network benefits (including care outside the service area) are available, unless specified otherwise. No deductible is required for Selections network benefits.

The deductible amount under this plan is $0 per member, per calendar year. There are no individual or family deductible amounts to be satisfied before benefits are available under this plan. Any references in this brochure relating to satisfaction of a deductible amount will be considered not applicable and the benefits of this plan will be provided, subject to all other provisions of this plan.

Any copays required by your plan, charges for services and supplies not covered by this plan, any expenses for services not subject to the deductible, and expenses for covered services or supplies in excess of the allowed amount, except as specified in the Emergency Care provision in the "What Do I Do When I Need Care?" section, will not apply to your deductible.

You and your dependents who become covered under this plan on its original effective date will be allowed to credit toward the deductible amount of this plan any amounts credited toward your deductible amount of your group's prior carrier for that calendar year, provided notification of the amount to be credited is received by the Company within 31 days of the effective date of this plan. Coverage under the plan with the group's prior carrier must be of the same type as this plan.

Family Deductible: If three or more covered family members reach eligible deductible expenses totaling three deductible amounts in a calendar year, no further deductible will be required from any family member during that calendar year.

Deductible Carry-Over: Covered expenses incurred during the last three months of a calendar year and applied to the deductible may also be applied to the next calendar year's deductible.

Family Accident Deductible: If two or more covered family members are injured in the same accident, they need to satisfy only one deductible for any benefits provided in that and the next calendar year as a result of the accident.

How to Submit Proof of Your Deductible: As you incur deductible expenses, your provider should bill the Company direct. If direct billing is not possible, submit your claim as specified in the "How Do I File A Claim?" section of this brochure as you incur expenses. You will receive itemized statements showing what amounts have been credited toward your deductible.

If Hospitalization Continues From One Calendar Year Into the Next: A second deductible will not be required for any treatment prior to your discharge from the hospital. Additional coinsurance also will not be required for any treatment prior to your discharge from the hospital if you have met the appropriate stoploss limit for the calendar year in which the hospitalization began.

STOPLOSS LIMITS

Your Selections plan has two separate limits called "stoploss limits" - one applies to services within the Selections network and the other to benefits within the extended network (including care outside the service area). The stoploss amounts for both networks are as shown below:

Selections Network Stoploss Limit:	$2,500 per member $5,000 per family, per calendar year
Extended Network Stoploss Limit:	$10,000 per member $20,000 per family, per calendar year

When your eligible out-of-pocket coinsurance expenses for the Selections network reach the appropriate stoploss limit, the payment level **for most benefits within that network** will increase to 100% of the allowed amount for the remainder of the calendar year. When your eligible out-of-pocket coinsurance expenses for the Extended Network reach the appropriate stoploss limit, the payment level for benefits within that network will increase to 90% of the allowed amount for the remainder of the calendar year. If two or more covered family members reach coinsurance expenses totaling two stoploss limits for each network in a calendar year, the stoploss requirement will be considered satisfied for that network for all family members during that calendar year. The coinsurance for Selections network benefits applies only to the Selections network stoploss and the coinsurance for extended network benefits applies only to the extended network stoploss. (Some benefits do not change to higher payment levels and the coinsurance for those benefits does not apply to the stoploss limits. Those exceptions are noted throughout the brochure.)

PAYMENT SCHEDULE

The schedule below shows many of the main benefits included in your plan. Additional benefits may in some cases be available and will be described in the "Benefits" section of this brochure. After you have satisfied your copay and any deductible requirements, benefits will be provided at the payment levels specified below. Please read the entire brochure for details on these and other benefits, specific benefit limitations and maximums, and exclusions.

Benefit Payment Level for Services Provided by Selections, Preferred Plan, and Participating Providers Inside the Service Area: You may contact the Company for up-to-date information on Selections, Preferred Plan, and participating providers.

Benefit	Selections Network Benefits	Extended Network Benefits
Preventive Care	100%	not covered except routine colorectal cancer screening services and mammograms at 60%)
Professional Services (as described in the "Benefits" section including diagnostic x-ray and laboratory services)	100% (unless specified otherwise)	60% (unless specified otherwise)
Hospital Services* (inpatient and outpatient benefits including diagnostic x-ray and laboratory services) $75 copay per emergency room visit (waived if admitted)	100%	60%
Acupuncture	100%	60%
Ambulatory Surgical Center $75 copay per surgery (waived for diagnostic x-ray and laboratory services, chemotherapy, radium therapy and if admitted)	100%	60%
Chemical Dependency	100%	60%
Diabetes Care Training	100%	60%
Growth Hormone	100%	60%

Benefit	Selections Network Benefits	Extended Network Benefits
Home Health	100%	60%
Home Medical Equipment	80%	60%
Home Phototherapy	100%	60%
Hospice	100%	60%
Hospitalization for Dental Services	100%	60%
Infusion Therapy	100%	60%
Mammography	100%	60%
Maternity	100%	60%
Mental Disorders	100%	60%
Neurodevelopmental Therapy	80%	60%
Newborn Care	100%	60%
Occupational Injury	same as any condition	
Phenylketonuria Formulas	100%	60%
Preadmission Testing for Surgery	100%	60%
Prenatal Testing	100%	60%
Prostate Cancer Screening	100%	60%
Prostheses and Orthotics	80%	60%
Rehabilitative Services Inpatient Outpatient	 100% 80%	 60% 60%
Routine Hearing Exams	100%	not covered
Skilled Nursing Facility	100%	60%
Smoking Cessation	50%	50%
Special Equipment and Supplies	80%	80%
Spinal Manipulations	100%	100%
Sterilization Procedures	100%	60%
Temporomandibular Joint Disorders	80%	60%
Transplants	100%	not covered

*Services and supplies required to treat a medical emergency, inside the service area, will be provided at the Selections Network Benefit payment level as specified in the Emergency Care provision in the "What Do I Do When I Need Care?" section.

Benefit Payment Level for Services Provided by Recognized Providers Inside the Service Area:

Benefit	Selections Network Benefits	Extended Network Benefits
Ambulance Services	80%	80%
Blood Bank	80%	80%
Repair of Teeth	80%	80%
Temporomandibular Joint Disorders (services of dentists)	80%	60%

Benefit Payment Level for Services Provided Outside the Service Area: If you receive care outside the service area, you will receive the same benefits as in the extended network but at a higher level. Emergency care and services received from Preferred Plan or participating providers will be payable at the Selections network level. Otherwise, all benefits payable at 70% in the extended network will be payable at 80% of the allowed amount outside the service area, whether or not a medical emergency. If you live inside the service area and become admitted as an inpatient while traveling outside the service area, you will receive the Selections network benefits if you follow special notification procedures and other requirements. (See the "What Do I Do When I Need Care?" section.)

BENEFITS

All covered benefits explained on the following pages are provided after satisfaction of any copay amounts. All extended network benefits are provided as specified after satisfaction of any deductible.

All covered benefits are subject to the **limitations, exclusions, and provisions** of this plan, and services and supplies must be medically necessary. Limited benefits are not cumulative and unused portions of them cannot be carried over from one calendar year to another calendar year, except as otherwise specified. Inside the service area, you must receive services from Selections, Preferred Plan, or participating providers (see "Definitions" section), as outlined in the Payment Schedule, to be eligible for the benefits of this plan. The services of recognized providers (see "Definitions" section) inside the service area are only available for benefits as outlined in the Payment Schedule. Benefits for medical emergencies will be provided as specified in the Emergency Care provision of the "What Do I Do When I Need Care?" section. Benefits are identical for subscribers and dependents, except where otherwise specified.

Preventive Care: The services of a Personal Care Provider will be provided when performed on an outpatient basis at the same level as benefits for illness conditions. The services of a Selections physician, or a Preferred Plan or participating audiologist will be provided for routine hearing examinations without a referral from the Personal Care Provider. A female may also refer herself directly to the following providers for covered services: Selections physician, Selections advanced registered nurse practitioner specializing in women's health and midwifery, Selections midwife, or Selections physician's assistant. The following services will be provided:

- Routine well baby care from birth.
- Routine pediatric, routine gynecological and adult physical examinations.
- Pediatric and adult immunizations.
- Office calls and related laboratory and x-ray services for routine cancer screening including preventive surgeries. (Routine mammography and routine prostate cancer screening services are covered separately under the "Benefits" section and are not part of the Preventive Care Benefit.)
- Routine colorectal cancer screening services, including but not limited to, colonoscopies, sigmoidoscopies, fecal occult tests and barium enemas.
- One routine hearing examination per calendar year.

No other routine benefits for benefits for glasses, contact lenses, or hearing aids will be provided under this plan unless specifically stated. Except for routine colorectal cancer screening services, routine mammograms, and routine prostate cancer screening services, Preventive Care Benefits are not available outside the Selections network. Copays apply to all services except x-ray and laboratory.

Professional Services: The services of a provider who is not a facility that provides inpatient services will be provided for injury and illness, including x-ray, laboratory, surgery, second opinions, and injectable drugs for covered conditions in the office, home, hospital or skilled nursing facility. The services of a provider who is a physician, a physician's assistant, a midwife, or an advanced registered nurse practitioner specializing in women's health and midwifery will be provided to a female when she refers herself directly for covered women's health care services. Covered women's health care services include gynecological care and general examinations as medically appropriate and medically appropriate follow-up visits. To receive the Selections network level of benefits for covered women's health care services, a female may refer herself directly to a Selections provider who is a physician, a physician's assistant, a midwife, or an advanced registered nurse practitioner specializing in women's health and midwifery. The Selections network level of benefits of this plan will be provided when you self-refer directly to a chiropractor for covered chiropractic services. Copays apply to all services except outpatient surgery, x-ray, laboratory and inpatient care.

Hospital Services: The inpatient and outpatient services of a hospital will be provided for injury and illness (including services of staff providers billed by the hospital). Room and board is limited to the hospital's average semiprivate room rate, except where a private room is determined to be medically necessary. You will be responsible to pay the applicable copay for each outpatient surgery or hospital emergency room visit. All other services of the hospital outpatient department, except radiation and chemotherapy, are subject to the outpatient professional copay.

Acupuncture: The benefits of this plan will be provided to a 12 visit limit per calendar year for acupuncture services, except that acupuncture for chemical dependency treatment will be provided separately under the Chemical Dependency Benefit of this plan.

Ambulance Services: The services of an ambulance company (ground or air ambulance service) will be provided to the nearest hospital equipped to render the necessary treatment, if other transportation would endanger your health and the purpose of the transportation is not for personal or convenience reasons.

Ambulatory Surgical Center: The services and supplies of an ambulatory surgical center are subject to the applicable copay (waived for diagnostic x-ray and laboratory services, chemotherapy, radium therapy, and if admitted) and will be provided for injury or illness. Services provided by Tacoma Ambulatory Surgical Center will be provided at 100% of the allowed amount and the copay for outpatient surgery is waived.

Blood Bank: The services and supplies of a blood bank will be provided.

Chemical Dependency: The services and supplies of a chemical dependency treatment program will be provided for medically necessary inpatient and outpatient treatment for chemical dependency, including supportive services. Benefits will be provided to a maximum allowance of $14,500 every two calendar years. Medically necessary detoxification will be covered as a medical emergency and expenses incurred will not accrue to the $14,500 two calendar year maximum if the member is not enrolled in other chemical dependency treatment.

Acupuncture services related to chemical dependency treatment will be provided under this Chemical Dependency Benefit and will accrue to the overall Chemical Dependency Benefit maximum. Acupuncture services provided under this Chemical Dependency Benefit do not accrue to the 12 visit limit per calendar year, as specified in the Acupuncture Benefit.

Prescription drugs related to chemical dependency treatment and prescribed and dispensed through a chemical dependency treatment facility will be provided under the benefits of this Chemical Dependency Benefit and will accrue to the overall Chemical Dependency Benefit maximum.

Except in cases of medically necessary detoxification services, the program must submit prenotification of treatment at least 10 days before treatment begins, whenever reasonably possible.

When the member is under court order to undergo a chemical dependency assessment or in other situations pending legal action related to chemical dependency, the Company reserves the right to require the member, at the member's expense, to provide a chemical dependency treatment plan and an initial chemical dependency assessment performed by a chemical dependency counselor employed by a chemical dependency treatment program, at least 10 days before treatment begins.

For the purpose of this Chemical Dependency Benefit, "medically necessary" means indicated in the *Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II* as published in 1996 by the American Society of Addiction Medicine.

No benefits will be provided for information and referral services; information schools; Alcoholics Anonymous and similar chemical dependency programs; long-term care or custodial care; tobacco cessation programs, except as provided in the Smoking Cessation Benefit of this plan; and emergency service patrol. No other Chemical Dependency Benefits will be provided under this plan, except as described above for detoxification.

Diabetes Care Training: The outpatient benefits of this plan will be provided for diabetic self-management training and education, including nutritional therapy, if recommended by a provider with expertise in diabetes.

Diabetes Supplies and Equipment: The benefits of this plan will be provided for supplies and equipment for the treatment of diabetes. For Professional Services, Diabetes Care Training, Home Medical Equipment, Prostheses and Orthotics, and Prescription Drugs Benefits, see those benefits of this plan.

Growth Hormone: Services and supplies will be provided for growth hormone when performed and billed by an infusion therapy provider for the following:

- For children with growth hormone deficiency, Turner's syndrome, chronic renal insufficiency, Prader-Willi syndrome, neonatal hypoglycemia associated with growth hormone deficiency, or for other conditions determined by the Company to be a covered benefit since this plan was issued.
- For adults with growth hormone deficiency as a result of hypothalamic or pituitary disease due to destructive lesion of the pituitary, or peri-pituitary area, as a result of treatment or surgery, or for other conditions determined by the Company to be a covered benefit since this plan was issued.

Growth hormone treatment of these listed conditions is covered when authorized by the Company in advance. No other benefits for growth hormone will be provided under this plan.

Home Health:

Eligibility: The services of a home health agency will be covered in your home for treatment of an illness or injury, subject to the conditions and limitations specified below.

All of the following must be satisfied to be covered under this benefit:

- You must be homebound, which means that leaving the home could be harmful, involves a considerable and taxing effort and you are unable to use transportation without the assistance of another.

- Your condition must be serious enough to require confinement in a hospital or skilled nursing facility in the absence of home health services.

Covered Services: Benefits are limited to the following services in your home and must be provided by employees of and billed by the home health agency:

- Intermittent skilled nursing services.
- Skilled physical, occupational, and speech therapy services.
- Respiratory therapy services.
- Skilled medical social services.
- Home health aide services. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Medical supplies dispensed by the home health agency that would have been provided on an inpatient basis.
- Nutritional guidance.

Note: For professional services, home medical equipment, or infusion therapy see the other benefits of this plan.

Limitations and Exclusions: Home Health Benefits are limited to a maximum of 130 visits per calendar year. If the benefit is exhausted, you may apply to the Company for an extension of benefits. Limited extensions may be granted by the Company if it determines that the treatment is medically necessary. Any expenses for home care which qualify both under this benefit and under any other benefit of this plan may be covered only under the benefit the Company determines to be the most appropriate.

No benefits will be provided for the following:

- Services normally provided under a hospice program.
- Services to other family members.
- Services of volunteers, household members, family or friends.
- Food, clothing, housing or transportation. (See the Ambulance Services Benefit of this plan.)
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.
- Homemaker or housekeeping services, except as specifically provided under the home health aide benefit.
- Financial or legal counseling services.
- Custodial or maintenance care.
- Hourly care services.

- Services or supplies not specifically set forth as a covered benefit, or limited or excluded under the regular limitations and exclusions of this plan.

Home Medical Equipment: Home medical equipment rented or purchased (if approved by the Company) from a home medical equipment company will be provided for therapeutic use. Such equipment includes crutches, wheelchairs, kidney dialysis equipment, standard hospital beds, equipment for the administration of oxygen, and medically necessary diabetic equipment, such as blood glucose monitors, insulin infusion devices, and insulin pumps including accessories to the pumps. To be covered, equipment must meet certain criteria established by the Company. Equipment ordered before your effective date of coverage will not be provided. Equipment ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of home medical equipment due to normal use or growth of a child will be provided.

"Home medical equipment" means the equipment can withstand repeated use; its only function is for treatment of the medical condition, or it contributes to the improvement of function related to the condition and is generally not useful in the absence of the condition; and it is appropriate for home use. Equipment whose primary purpose is preventing illness or injury, items primarily designed to assist a person caring for the patient, and items generally useful in the absence of the condition will not be covered.

No benefits will be provided for items such as, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, corrective shoes, heating pads, enuresis (bed wetting) training equipment, hearing aids, exercise equipment, weights, whirlpool baths, keyboard communication devices, adjustable beds, orthopedic chairs, home birthing tubs, or personal hygiene items. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. The Company may elect to provide benefits for a less costly alternative item.

Home Phototherapy: Services and supplies furnished by a home phototherapy provider will be provided for newborn hyperbilirubinemia (newborn jaundice).

Hospice:

Eligibility: If you or one of your dependents is terminally ill, the services of a hospice will be covered for palliative care (medical relief of pain and other symptoms) for the terminally ill patient, subject to the conditions and limitations specified below.

Covered Services in Your Home: Benefits are limited to the following services in your home and must be provided by employees of and billed by the hospice:

- Nursing services.
- Physical, speech, occupational, and respiratory therapy services.
- Medical social services.
- Home health aide services. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis.
- Nutritional guidance.
- Respite care for a minimum of four or more hours per day (continuous care of the patient to provide temporary relief to family members or friends from the duties of caring for the patient).

Note: For professional services, home medical equipment, or infusion therapy see the other benefits of this plan.

Covered Inpatient Services: When you are confined as an inpatient in a hospice that is not a hospital or skilled nursing facility, the same benefits that are available in your home will be available to you as an inpatient. Room and board is limited to the hospice's average semiprivate room rate, except where a private room is determined to be medically necessary. The services must be provided by employees of and billed by the hospice. This inpatient Hospice Benefit will be limited to 14 days during the six-month benefit period. For services in a hospital or skilled nursing facility, see the Hospital Services and Skilled Nursing Facility Benefits of this plan.

Limitations and Exclusions: Hospice Benefits are limited to a maximum of six months. In addition, Hospice Benefits will have the following limits:

- Visits of four or more hours in which skilled care is required by a registered nurse, licensed practical nurse or home health aide, will be limited to a combined total of 120 hours.
- Respite care of four or more hours per day in which no skilled care is required will be limited to a combined total of 120 hours per three-month period.
- Any expenses for hospice care that qualify both under this benefit and under any other benefit of this plan will be covered only under the benefit the Company determines to be the most appropriate.

If the benefit is exhausted, you may apply to the Company for an extension of benefits. Limited extensions may be granted if the Company determines that the treatment is medically necessary.

No benefits will be provided for the following:

- Services for spiritual or bereavement counseling.
- Services to other family members.
- Services of volunteers, household members, family or friends.
- Food, clothing, housing or transportation. (See the Ambulance Services Benefit of this plan.)
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.
- Homemaker or housekeeping services, except as specifically provided under the home health aide benefit.
- Financial or legal counseling services.
- Custodial or maintenance care, except that benefits will be provided for palliative care to a terminally ill patient, subject to the limits stated.
- Services or supplies not specifically set forth as a covered benefit, or limited or excluded under the regular limitations and exclusions of this plan.

Hospitalization for Dental Services: Services and supplies of this plan for hospitalization will be provided for dental services (including anesthesia), if hospitalization is medically necessary to safeguard your health. Benefits will be provided to $1,000 per calendar year and will cover the services of a physician, an ambulatory surgical center, and the inpatient and outpatient services of a hospital. Benefits are not available for the charges of a dentist; hospitalization for myofascial pain syndrome and any related appliances; or hospitalization for malocclusions or other abnormalities of the jaw, except when specified otherwise.

Infusion Therapy: Services and supplies for infusion therapy will be provided. Drugs and supplies used in conjunction with infusion therapy will be provided only under this Infusion Therapy Benefit.

Mammography: The x-ray benefits of this plan will be provided for screening or diagnostic mammography services, if recommended by a physician, physician's assistant, or advanced registered nurse practitioner.

Maternity: Medical services including prenatal and postnatal treatment of pregnancy (including false labor), normal or cesarean delivery, and voluntary termination of pregnancy shall be treated the same as any other illness or injury and are provided for the female subscriber or subscriber's female spouse for services incurred while she is covered under this plan. Covered inpatient and postpartum

services will be provided when ordered by the attending provider in consultation with the female subscriber or the subscriber's female spouse. These Maternity Benefits are not available for dependent daughters. Treatment of complications arising from pregnancy will be provided the same as any other illness or injury. Complications of pregnancy include, but are not limited to, diabetes if onset is after conception, fetal distress, and toxemia. Charges for false labor or charges in connection with a normal pregnancy, cesarean section, or voluntary termination of pregnancy, are treated as Maternity Benefits except any complications that may arise. A female may refer herself directly to a physician, physician's assistant, midwife, or advanced registered nurse practitioner specializing in women's health and midwifery for the maternity care benefits of this plan. The Selections network level of benefits will be provided to a female when she refers herself directly to the Selections providers listed above.

See the "What Else Do I Need To Know?" section of this brochure for provisions that apply when coverage terminates.

Neurodevelopmental Therapy: The benefits described below will be provided for the treatment of neurodevelopmental delay when treatment is performed for the purpose of restoring and improving function for children age six and under. In addition, this benefit includes maintenance services where significant deterioration of the member's condition would result without the service. Benefits will be provided as follows:

- Physical, speech and occupational therapy will be provided in the office, home or hospital outpatient department.
- All treatment must be prescribed by a Selections, Preferred Plan, or participating provider.
- Regular inpatient Hospital Services and Skilled Nursing Facility Benefits will be provided for an inpatient neurodevelopmental therapy admission when care cannot safely be provided on an outpatient basis. Hospital services must be provided in a hospital approved by the Company for rehabilitative care.
- "Neurodevelopmental delay" means a delay in normal development which is not related to a documented illness or injury.
- Benefits will be limited to $5,000 per calendar year for Selections network services or $2,500 per calendar year for extended network services. Copays apply to outpatient treatment. You will not be eligible for both the Rehabilitative Services Benefit and this benefit for the same services for the same condition. (Not subject to the stoploss provision.)
- No benefits will be provided for custodial care; maintenance (except as specified above); nonmedical self-help; recreational, educational,

or vocational therapy; mental disorder care; chemical dependency rehabilitative treatment; gym or swim therapy.

Newborn Care: The regular benefits of this plan will be provided for routine care, illness, accidental injury, or physical disability, including congenital anomalies, for the newborn child for up to 21 days following birth when the subscriber or subscriber's spouse is eligible for the Maternity Benefits of this plan. Such benefits will not be subject to the application requirements (if any) for newborns described in the "When Am I Eligible For Coverage?" section of this brochure. Benefits will be subject to all provisions, limitations, and exclusions of this plan, including but not limited to, the selection of a Personal Care Provider. No benefits will be provided after day 21 unless the newborn is enrolled as specified in the "When Am I Eligible For Coverage?" section of this brochure.

When the subscriber or subscriber's spouse is not eligible for the Maternity Benefits of this plan, the Professional Services and Hospital Services Benefits of this plan will be provided for routine care for her newborn child while hospitalized for the first 72 hours following birth, not subject to the application requirements, if any, for newborns described in the "When Am I Eligible For Coverage?" section of this brochure.

Occupational Injury: The benefits of this plan will be provided for occupational injury. "Occupational injury" for the purpose of this benefit means any illness or injury arising out of, or in the course of, an activity pertaining to any trade, business, employment or occupation for wage or profit. Benefits for services and supplies to treat occupational injury will only be provided to subscribers and spouses who are legally exempt from state industrial insurance, workers' compensation, or similar coverage, and who are not covered under any such insurance or coverage.

Preadmission Testing for Surgery: The services of a physician and hospital will be provided for outpatient preadmission testing for surgery at the hospital where you will be confined, if you are admitted within 48 hours after testing begins.

Prenatal Testing: Benefits will be provided for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy, when medically necessary in accordance with Washington State Board of Health standards.

Prostate Cancer Screening: The Professional Services and Hospital Services laboratory Benefits of this plan will be provided for prostate cancer screening services, if recommended by a physician, physician's assistant or advanced registered nurse practitioner.

Prostheses and Orthotics: Benefits will be provided for the purchase of braces, splints, orthopedic appliances and other orthotic supplies, and for purchase of a prosthesis for functional reasons when replacing a missing body part, when obtained from a prosthetic and orthotic supply provider. No benefits will be provided for cosmetic prostheses except for necessary external and internal breast prostheses following a mastectomy. An item ordered before your effective date of coverage will not be provided. An item ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of an item due to normal use or growth of a child will be provided. The Company may elect to provide benefits for a less costly alternative item. For other special equipment, see the Special Equipment and Supplies Benefit of this plan.

Rehabilitative Services: The benefits described below will be provided for rehabilitative care when medically necessary to restore and improve function previously normal but lost due to a documented illness or injury, including function lost as a result of congenital anomalies. Illnesses and injuries include, but are not limited to:

- *Illness.* Any documented illness (e.g. stroke, viral infection, or bacterial infection) that occurs during prenatal, perinatal, childhood, adolescence, or adulthood.
- *Injury.* Any documented injury that occurs during prenatal, perinatal, childhood, adolescence, or adulthood.

Benefits will be provided as follows:

- Regular inpatient Hospital Services and Skilled Nursing Facility Benefits will be provided for an inpatient rehabilitative admission for physical, speech and occupational therapy, to a maximum of $50,000 for Selections network providers or $25,000 for extended network providers per condition. Hospital services must be provided in a hospital approved by the Company for rehabilitative services. Benefits will be limited to services rendered within three calendar years from the date of your first hospital or skilled nursing facility rehabilitative care admission.
- Physical, occupational, or speech therapy in the office, home, or hospital outpatient department approved by the Company for rehabilitative care will be paid to $5,000 per calendar year for Selections network providers or $2,500 per calendar year for extended network providers. Copays do not apply to outpatient treatment. (Not subject to the stoploss provision.)
- All treatment must be prescribed by a Selections, Preferred Plan, or participating provider.
- You will not be eligible for the Neurodevelopmental Therapy Benefit and this benefit for the same services for the same condition.

- No benefits will be provided for custodial care; maintenance therapy; nonmedical self-help; recreational, educational, or vocational therapy; mental disorders care; learning disabilities or developmental delay; chemical dependency rehabilitative treatment; gym or swim therapy; and any services or supplies specifically excluded under the regular limitations and exclusions of this plan. "Maintenance therapy" means a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, any additional therapy provided is considered to be maintenance therapy.

Repair of Teeth: The services of a dentist (D.M.D. or D.D.S.) or a denturist licensed under Title 18 RCW will be provided for repair of accidental injury (trauma) to natural teeth that are whole and functionally sound or have been restored to a sound functional capacity. Benefits will be provided for the treatment of the injury for a period of 12 consecutive months from the date of the injury. This benefit is supplemental to any dental plan you may have. This benefit will not be provided for injury caused by biting or chewing or for dental implants. No other charges of a dentist or denturist will be covered under this plan, except when specifically provided otherwise. Benefits are not contingent upon referral by your Personal Care Provider.

Skilled Nursing Facility: The inpatient services and supplies of a skilled nursing facility will be provided for illness, accidental injury, or physical disability, limited to 100 days per calendar year. Room and board is limited to the skilled nursing facility's average semiprivate room rate, except where a private room is determined to be medically necessary. Your physician must submit for approval by the Company and periodically review a written treatment plan specifically describing the services to be provided. No custodial care is provided. (Not subject to the inpatient admission copay or the stoploss provision.)

Smoking Cessation: The services of a physician, psychologist, or smoking cessation provider, will be provided for a smoking cessation program to a lifetime maximum of $500. To receive benefits for smoking cessation, you must complete the full course of treatment. No benefits will be provided under this benefit for inpatient services; vitamins, minerals and other supplements; acupuncture; over-the-counter drugs or prescription drugs prescribed by your covered provider to ease nicotine withdrawal, however, drugs prescribed to ease nicotine withdrawal are covered under the Prescription Drugs Benefit of this plan, if any; books or tapes; or hypnotherapy unless performed

by a participating provider. No other benefits for smoking cessation will be provided under this plan. Benefits are not contingent upon referral by your Personal Care Provider. (Not subject to the stoploss provision.)

Special Equipment and Supplies: The following will be provided: casts; ostomy bags and related supplies; catheters; surgical appliances; syringes and needles for allergy injections; dressings medically necessary for wounds, cancer, burns or ulcers; and FDA-approved contraceptive supplies, devices, and implants, requiring a prescription. Formulas for the treatment of phenylketonuria will be provided as specified in the Payment Schedule under "Phenylketonuria Formulas." Items ordered before your effective date of coverage will not be provided. Items ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of items due to normal use or growth of a child will be provided.

Spinal Manipulations: The Professional Services Benefits of this plan will be provided to a maximum of 15 spinal manipulations per calendar year.

Sterilization Procedures: Benefits will be provided for sterilization procedures. Reversals of these procedures will not be covered.

Temporomandibular Joint Disorders (TMJ): Benefits will be provided for medical services for treatment of temporomandibular joint disorders. A TMJ disorder has 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. Benefits will be limited to a maximum of $1,000 per calendar year, not to exceed a lifetime maximum of $5,000. Copays apply to outpatient services.

"Medical services" for the purpose of this TMJ Benefit mean those services that are: 1) reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and 2) 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; and 3) recognized as effective, according to the professional standards of good medical practice; and 4) not investigational or primarily for cosmetic purposes.

All services must be provided or ordered by your physician. Benefits for all surgical services related to TMJ must be authorized by the Company in writing, in advance. The Company will waive its

advance notification requirement for treatment commencing within 48 hours, or as soon as is reasonably possible as determined by the Company, after the occurrence of an accidental injury or trauma to the temporomandibular joint. No other benefits for TMJ will be provided by this plan.

Transplants: The Selections network benefits of this plan will be provided for all medically necessary services or supplies related to all transplants, as determined by the Company, as follows:

Benefits: A transplant recipient who is covered under this plan will be eligible for the following transplants, subject to the conditions and limits described in this Benefit:

- Heart
- Heart/lung (combined)
- Kidney
- Pancreas
- Kidney/pancreas (combined)
- Islet cell
- Lungs - single/bilateral/lobar
- Liver
- Small bowel
- Small bowel/liver/multivisceral
- Cornea
- Hematopoietic stem cell support. Donor stem cells can be collected from either the bone marrow or the peripheral blood. Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor), or umbilical cord blood (only covered for certain conditions, as specified in this Transplants Benefit).
- Other transplants determined by the Company to be a covered benefit since the plan was issued.

A current list of covered transplants can be obtained by contacting the Company.

Benefits for all transplants are contingent upon referral by your Personal Care Provider, except as specified in the Outside the Service Area section of this benefit, and must be authorized by the Company in writing, in advance. Approval will be based on the member's medical condition, the qualifications of the providers, appropriate medical indications for the transplant, and appropriate, proven medical procedures for the type of condition. All transplants must be performed in a facility approved by the Company. If a transplant is not successful, retransplants will be covered, subject to the benefit limits specified.

Outside the Service Area: Benefits will be provided outside the service area, as specified in the Benefit Payment Level For Services Provided Outside The Service Area provision in the Payment Schedule. You must follow all requirements of this benefit including, but not limited to, obtaining advance approval from the Company and using a facility approved by the Company. However, obtaining a referral from a Personal Care Provider is not required.

Donor Organ Benefits: Donor organ procurement costs will be provided at 90% of the allowed amount to a maximum of $20,000 per transplant if the recipient is covered for the transplant under this plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other such medically necessary procurement costs as determined by the Company. Donor benefits will be charged against the recipient's benefit limits.

Limitations: Benefits for transplants will be limited as follows:

- With regard to autologous stem cell support, syngeneic stem cell support, and high-dose chemotherapy associated with autologous stem cell support or syngeneic stem cell support, coverage is available for treatment of the following malignancies/conditions: Non-Hodgkin's lymphoma; Hodgkin's lymphoma; neuroblastoma; acute lymphocytic or non-lymphocytic leukemias; germ cell tumor; multiple myeloma; Ewing's Sarcoma; Wilms Tumor; breast cancer; primary amyloidosis; and other malignancies/conditions determined by the Company to be a covered benefit since this plan was issued. Autologous stem cell support, syngeneic stem cell support, and high-dose chemotherapy associated with autologous stem cell support or syngeneic stem cell support for conditions other than those listed above or as determined by the Company to be a covered benefit since this plan was issued will not be covered.
- With regard to allogeneic stem cell support and high-dose chemotherapy associated with allogeneic stem cell support, coverage is available for treatment of the following malignancies/conditions: Non-Hodgkin's lymphoma; Hodgkin's lymphoma; neuroblastoma; acute lymphocytic or non-lymphocytic leukemias; chronic myelogenous leukemia; aplastic anemia; severe combined immunodeficiency (not AIDS); Wiskott-Aldrich syndrome; infantile malignant osteopetrosis; homozygous beta-thalassemia; myelodysplastic syndromes; mucopolysaccharidoses; mucolipidoses; sickle cell anemia; Kostmann's syndrome; leukocyte adhesion deficiencies; x-linked lymphoproliferative syndrome; megakaryocytic thrombocytopenia; other malignancies/conditions determined by the Company to be a covered benefit since this plan

was issued. Allogeneic stem cell support and high-dose chemotherapy associated with allogeneic stem cell support for conditions other than those listed above or as determined by the Company to be a covered benefit since this plan was issued will not be covered.

Limitations and Exclusions: No benefits will be provided for the following:

- Nonhuman, artificial or mechanical transplants.
- When the recipient is not covered under this plan.
- Investigational procedures.
- Services in a facility not approved by the Company.
- Donor and procurement services and costs incurred outside the United States unless approved by the Company.
- Stem cell support and high-dose chemotherapy associated with stem cell support, except as specified in this Transplants Benefit.
- When donor benefits are available through other group coverage.
- When government funding of any kind is provided.
- Travel, lodging, food, or transportation costs.
- Any services or supplies relating to the transplant if you do not receive a referral from and have your care coordinated by your Personal Care Provider, except as stated in the Outside the Service Area section of this benefit.

Mental Disorders: Benefits for mental disorders under this plan are limited to the following:

The following benefits for mental disorder treatment will be provided during a calendar year:

Inpatient care, partial hospitalization, and residential treatment. Two partial hospital days or two residential treatment days will count as one inpatient day.	9 days per calendar year
Outpatient care (subject to the Professional services copay)	51 visits per calendar year

On average, members covered under our Selections plans who are provided mental disorder services use fewer than 10 outpatient visits per calendar year. Normally, the treatment goal is to allow members to regain stability and manage their symptoms. However, treatment goals will depend on the diagnosis of the disorder. Outpatient mental disorder treatment must be provided by a physician (M.D. or D.O.), psychologist (PhD or PsyD), advanced registered nurse practitioner (ARNP), licensed independent clinical social worker

(LICSW), licensed mental health counselor (LMHC), licensed marriage and family therapist (LMFT) (however, marriage counseling will not be covered and family counseling will only be covered when the identified member is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment), or a licensed community mental health agency.

Inpatient mental disorder care must be provided by an accredited general or psychiatric hospital, a state mental hospital as defined in state law, or a licensed community mental health agency that has an accredited inpatient facility.

Services which may be covered under this benefit include, but are not limited to, diagnostic testing and treatment for mental disorders with a congenital or physical basis, diagnostic testing for learning disabilities, mental disorders related to a self-inflicted injury or attempted suicide, and mental disorders related to an eating disorder. Some benefit restrictions may apply. See the "When Won't Things Be Covered?" section for specific services excluded under this plan.

No other benefits for treatment of mental disorders will be provided under this plan.

Prescription Drugs: Prescription drugs (including oral contraceptives) and other covered items will be provided in full as described below after you have paid the specified copay amount. Prescription drugs and other covered items must be furnished by a participating pharmacy or a participating mail order supplier. There are more than 1,200 participating pharmacies in our Washington State network from which to choose, as listed in our current provider directory. A list of these participating pharmacies, along with a list of participating out-of-state pharmacies is available on our Web site at www.regencerx.com. **Benefits will be subject to any applicable limitations, and exclusions, except that Prescription Drugs Benefits will not be subject to the coordination of benefits provisions or to any deductible or stoploss provisions described in this plan.**

Getting Your Prescription Filled:

- Present your identification card at a participating pharmacy.
- Pay your applicable copay amount for each prescription dispensed. Your applicable copay amount varies as a result of the day supply prescribed.
- Prescription drugs furnished by a participating pharmacy will be limited to a 90-day supply as specified below.

Using Our Mail Order Service:

- Pay your applicable copay amount for each prescription dispensed (up to a 100-day supply). Your applicable copay amount will not vary as a result of the day supply prescribed.
- Send an order form and the prescription along with your copay amount to the address listed on the mail order service form.
- Prescription drugs furnished by mail order will be limited to a 100-day supply per purchase, except that certain drugs, including but not limited to antidepressants, narcotics, and other select medications may be limited to a lesser supply as indicated on your prescription or as required by the Company.
- Drugs requiring continuous refrigeration may not be available through mail order service.

Covered Items: Prescription drugs will be covered when medically necessary for the treatment of an illness, injury, or disability covered under this plan, subject to all provisions described below. Other items covered under this benefit and requiring a prescription include:

- Legend vitamins for prenatal care.
- Smoking cessation prescription drugs and medications, limited to a 90-day lifetime maximum supply.
- Diabetic supplies, including insulin and insulin syringes.
- Viagra, Cialis, and Levitra; limited to 8 units per month.
- Oral contraceptive drugs will be provided for a single copay per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one copay per monthly cycle.

Formulary: A formulary is a list of selected generic and brand-name preferred drugs, which is established, reviewed, and updated routinely by the Company. You will be required to pay more if the drug does not appear in the formulary. All drugs are reviewed and selected for inclusion in the Company's formulary by an outside committee of providers, including physicians and pharmacists. Drugs are selected based on published scientific evidence and support proper use and cost-effective medication decisions. If clinical data show several drugs are equally effective, the committee usually chooses the most cost-effective ones. For convenience, the list is available on our Web site at www.regencerx.com.

Copays: You will be responsible for paying the appropriate copay level as specified below for each covered prescription or refill.

Tier 1 – Generic Formulary Drugs – means drugs included in the formulary that are equivalent to the brand-name version, are marketed and sold by more than one source, and are listed in widely

accepted references as a generic drug based on manufacturer and price. Equivalent means the U.S. Food and Drug Administration (FDA) ensures that the generic must: a) have the same active ingredients found in the brand-name version; b) meet FDA specifications for quality, purity, and potency; and c) have the same medical effect as the brand-name version.

Participating Pharmacies

1 – 30 Day Supply	20% of the allowed amount to a maximum of $5.00
31 – 60 Day Supply	20% of the allowed amount to a maximum of $10.00
61 – 90 Day Supply	20% of the allowed amount to a maximum of $15.00

Participating Mail Order Service

1-100 Day Supply	20% of the allowed amount to a maximum of $15.00

Tier 2 – Brand-Name Formulary Drugs – means drugs included in the formulary that are under patent and are generally marketed and sold by only one source.

Participating Pharmacies

1 – 30 Day Supply	20% of the allowed amount to a maximum of $25.00
31 – 60 Day Supply	20% of the allowed amount to a maximum of $50.00
61 – 90 Day Supply	20% of the allowed amount to a maximum of $75.00

Participating Mail Order Service

1-100 Day Supply	20% of the allowed amount to a maximum of $75.00

Tier 3 – Non-Formulary Drugs – means drugs that do not appear in the formulary list established by the Company.

Participating Pharmacies

1 – 30 Day Supply	20% of the allowed amount to a maximum of $50.00
31 – 60 Day Supply	20% of the allowed amount to a maximum of $100.00
61 – 90 Day Supply	20% of the allowed amount to a maximum of $150.00

Participating Mail Order Service

1-100 Day Supply	20% of the allowed amount to a maximum of $150.00

Limitations: Benefits for prescription drugs and other covered items will be limited as follows:

- Prescription drugs must be prescribed by a provider covered under the plan who is acting within the scope of his or her license.
- Certain prescription drugs require preauthorization from the Company before they are covered. Participating pharmacies have been provided with a list of those drugs along with preauthorization requirements.
- Prescription drugs related to transplants are covered under this Prescription Drugs Benefit, however, claims for such drugs will be applied to and are subject to the Transplants Benefit maximum of this plan.
- Certain drugs may be limited to a lesser supply as indicated on your prescription or as determined by the Company. Participating pharmacies have been provided with a list of those drugs.
- Any drug purchased outside the United States must have an equivalent to a prescription drug approved by the FDA to be a covered benefit under this plan, and must be either:
  - Associated with a medical emergency while you are traveling. When submitting a claim for reimbursement, you will be responsible for notifying the Company that the prescription was required for a medical emergency; or
  - When you are residing outside the United States. When submitting a claim for reimbursement, you will be responsible for notifying the Company that your residence is outside the United States. The medication needs to be purchased in the country in which you are residing, except for a medical emergency.
- The Company may require you to obtain all prescriptions from a single participating pharmacy when reasonably necessary.

Exclusions: The following items are not covered under this Prescription Drugs Benefit due to plan exclusions or, as noted, covered under another benefit of this plan:

- Any items limited or excluded by this plan, except where specifically provided.
- Appetite suppressants and drugs for weight loss.
- Drugs or medications used for cosmetic purposes.
- Drugs dispensed by a non-participating pharmacy, except when specifically provided for cases of emergency or outside the service area.

- Inside the United States, any prescription drug that has not been approved by the FDA, including compounded products with active ingredient(s) that have not been approved by the FDA.
- Any drugs or items obtained from a participating pharmacy when you fail to present the identification card.
- Over-the-counter medications (OTC) and any prescription medication with the same active ingredients and in the same strength as an over-the-counter product.
- Replacement prescriptions resulting from loss, theft, or breakage.
- Growth hormone, except as specified in the Growth Hormone Benefit of this plan.
- Injectable drugs, except as specified in the Professional Services Benefit of this plan.
- Any drugs or items in excess of the specific limits described above.

Vision Care Eye Examination For Retirees with the Vision Exam Option Only: Benefits will be provided for the services of a Personal Care Provider, physician or optometrist at 100% of the allowed amount for Selections network providers and 60% of the allowed amount for extended network providers for one routine eye examination per calendar year to determine the need for a new or changed prescription for corrective lenses. Hardware and fittings for contact lenses are not covered.

WHEN WON'T THINGS BE COVERED?

WAITING PERIODS

Transplant Waiting Period: There is no transplant waiting period under this plan.

Preexisting Condition Waiting Period: There is no preexisting condition waiting period under this plan.

LIMITATIONS AND EXCLUSIONS

No benefits are provided for the following, or for any direct complications or consequences thereof, unless specifically stated otherwise below or unless specifically provided for in the "Benefits" section.

- Acupuncture, except as specified in the Acupuncture and Chemical Dependency Benefits in the "Benefits" section.
- Addiction to or abuse of drugs, alcohol or any other chemical substance whether legal or illegal, except as specifically provided in the Chemical Dependency Benefit in the "Benefits" section.
- Ambulance services, except as specified in the Ambulance Services Benefit in the "Benefits" section.
- Any expenses in connection with impotency, frigidity, sterility and infertility, including in-vitro fertilization, artificial insemination, embryo transfer, fertility drugs (including, but not limited to Clomid, Pergonal, or Serophene) or any other artificial means of conception. However, a pregnancy resulting from such conception will be covered under the regular benefits of this plan, as applicable.
- Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program, except for facilities that are included on the Company's list of participating providers, and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Government facilities outside the service area will not be covered (except as required by law for emergency services).
- Charges for services or supplies that are above the allowed amount as defined in the "Definitions" section, except for medical emergencies.
- Charges that in the absence of this plan there would be no obligation to pay.
- Cosmetic surgery and supplies (including drugs) and the treatment of any direct or indirect complications of such surgery, except: 1) when related to an illness or injury; 2) for congenital anomalies;

and 3) for reconstructive breast surgery following mastectomies, to the extent required under federal and state law as follows:
a) reconstruction of the diseased breast; b) reconstruction of the nondiseased breast to produce a symmetrical appearance; and
c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas.

- Custodial care.
- Dental services, except as specified in the Repair of Teeth and Hospitalization for Dental Services Benefits in the “Benefits” section.
- Dyslexia treatment, except as specified in the Neurodevelopmental Therapy Benefit in the “Benefits” section; visual analysis, therapy or training; orthoptics.
- Hearing aids; this exclusion does not apply to cochlear implants.
- Home medical equipment, special equipment or supplies, prostheses, orthopedic or surgical appliances, braces, or foot care appliances, except as specifically provided in the Home Medical Equipment, Prostheses and Orthotics, and Special Equipment and Supplies Benefits in the “Benefits” section; home medical equipment provided by a home health or hospice agency may also be provided as specified in the “What Else Do I Need To Know?” section.
- Hospitalization for conditions for which the member is not usually hospitalized, such as common colds, minor cuts or bruises, removal of small tumors, and similar minor conditions.
- Injuries sustained while practicing for or competing in a professional or semiprofessional athletics contest. “Semiprofessional athletics” contest means an athletic activity for gain or pay, that requires an unusually high level of skill and a substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.
- Investigational services or supplies.
- Marital counseling; family counseling, except as provided in the Mental Disorders Benefit in the “Benefits” section.
- Neurodevelopmental therapy, except as specifically provided in the Neurodevelopmental Therapy Benefit in the “Benefits” section.
- Nursing services that are not included in a covered facility’s basic charge, except as specifically provided in the Professional Services, Home Health, and Hospice Benefits in the “Benefits” section. Private duty nursing or hourly nursing charges are not covered.
- Occupational injury or disease (including any arising out of self-employment), except as specifically provided in the Occupational Injury Benefit in the “Benefits” section.
- Over-the-counter contraceptive supplies and devices.

- Physical or psychiatric examinations or psychological testing for the purpose of continuing employment, licensure, legal proceedings, insurance, school admission, or sports activities, or which are conducted for purposes of medical research.
- Preventive care, except as specifically provided in the Preventive Care Benefit in the "Benefits" section.
- Radial keratotomy and photorefractive keratectomy and other similar surgeries.
- Rehabilitative care, including speech therapy, physical therapy or occupational therapy, except as specifically provided in the Home Health, Hospice, and Rehabilitative Services Benefits in the "Benefits" section.
- Routine eye and hearing examinations, including related x-ray and laboratory, unless otherwise listed as covered and except as specifically provided in the Vision Care Eye Examination for Retirees or Preventive Care Benefits in the "Benefits" section.
- Services and supplies not medically necessary (as defined in the "Definitions" section) for treatment of an illness or injury, unless otherwise listed as covered.
- Services or supplies that are payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance when such contract or insurance is issued to or makes coverage available to the member. Any benefits provided by or advanced by the Company contrary to this exclusion are provided solely to assist the member. By paying such benefits, the Company is not acting as a volunteer and is not waiving any right to reimbursement or subrogation. When no-fault insurance is available and benefit payments have not been exhausted or denied for reasons other than the medical treatment being: (a) not reasonable; (b) not necessary; (c) not related to the accident; or (d) not incurred within three years of the accident, it will be the member's responsibility to pursue their coverage through the no-fault carrier to obtain the available limits of the no-fault coverage.
- Services provided by a family member. A "family member" means the member's spouse, parent, or child.
- Services provided by recognized providers, except as specified in the Payment Schedule of this plan.
- Services provided by the group or any of its employees or agents.
- Spinal manipulations, except as specifically provided in the Spinal Manipulations Benefit in the "Benefits" section.
- Stem cell support and high-dose chemotherapy associated with stem cell support will be provided only under the Transplants Benefit in the "Benefits" section. No other benefits related to stem

cell support and high-dose chemotherapy associated with stem cell support will be provided under this plan.

- Surgery or treatment for sexual dysfunction/impotence or transsexualism.
- Surgery (including reversals), treatment, programs or supplies intended to result in weight reduction, regardless of diagnosis.
- Treatment and any appliances used in connection with temporomandibular joint disorders, malocclusions, myofascial pain syndrome, or other abnormalities of the jaw, except as specifically provided in the Temporomandibular Joint Disorders Benefit in the “Benefits” section.
- Treatment of any condition caused by or resulting from active participation in the armed forces in a war or insurrection.
- Treatment of any condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.
- Visits or consultations that are not in person, including but not limited to any telephone, Internet, or other electronic communication (except tele-medicine in remote locations, as approved by the Company), whether initiated by the member or the member’s provider.
- Mental disorders, including mental disorder treatment for anorexia nervosa, bulimia or other eating disorders, except as specifically provided in the Mental Disorders Benefit in the “Benefits” section.
- Drugs, except as specifically provided in the Prescription Drugs Benefit in the “Benefits” section. Inpatient benefits are provided for drugs in a hospital or skilled nursing facility. Preventive injections or immunizations will be covered only if specifically provided in the Preventive Care Benefit in the “Benefits” section. FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment: 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. (For definitions of “off-label,” “standard reference compendia,” and “peer-reviewed medical literature,” please see the “Definitions” section.) No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.
- Eyeglasses and contact lenses and the fitting thereof, except for the first intraocular lenses following cataract surgery.

MAXIMUM BENEFIT

The benefits of this plan are limited to a $2,000,000 lifetime maximum per covered person. This maximum applies to all combined benefits provided under this plan and any prior plans, if any, with the Company for your group. In addition, on January 1 of each calendar year the amount charged against your lifetime maximum will be reduced by $10,000.

HOW DO I FILE A CLAIM?

In the Service Area: Be sure to present your Selections identification card when receiving treatment. Filing claims for services of providers who have contracted with our Company is not necessary. If you receive a bill from your provider or hospital, please verify with the provider or hospital that the Company has been billed. At the time of service you should inform your provider about copays that are required on your plan. Arrangements for paying copays should be handled directly between you and your provider.

Outside the Service Area: The Company participates with other Blue Cross and/or Blue Shield Licensees in a program called BlueCard to process claims for care received outside the service area. If you receive care within the service area of a Blue Cross and/or Blue Shield Licensee, other than the Company, you may be able to take advantage of agreements between providers and the on-site Blue Cross and/or Blue Shield Licensee. By using your identification card, Preferred Plan and/or participating providers with those Licensees can file your claim with the on-site Blue Cross and/or Blue Shield Licensee. The Licensee will then send your claim electronically to the Company. We will inform the on-site Licensee of benefit information and the Licensee will then pay the provider as appropriate. When your claim is processed, you will receive an explanation of claims processing that will specify any amount you owe the provider. You will not be responsible for any balances beyond any deductible, copay, and coinsurance amount. You will also, most likely, avoid having to pay for your entire service up front.

When you obtain health care services through the BlueCard Program outside the Service Area, the amount you pay for covered services is usually calculated according to the lower of:

- The billed charges for the services, or
- The “negotiated price” that the other Blue Cross and/or Blue Shield Licensee passes on to us.

The negotiated price will, most often, be a simple discount which reflects the actual price paid by the other Blue Cross and/or Blue Shield Licensee. But sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements, and non-claim transactions, with the Licensee’s providers or provider groups. The negotiated price may also be billed charges reduced to reflect an average expected savings with the Licensee’s providers or provider groups. This price may result in a greater variation from the actual price than will the estimated price.

The negotiated price may be prospectively adjusted to correct for past overestimation or underestimation of prices. However, the amount you pay is considered a final price.

In addition, state laws may require a small number of Licensees to use a method of calculating the amount you are responsible for paying that does not reflect the entire savings realized, or expected to be realized, on a particular claim for covered services or to add a surcharge. If you receive covered services in one of those states, the amount you are responsible for paying will be calculated using the individual state's statutory requirements.

You are entitled to benefits for covered health care services received by you either inside or outside the Service Area. Due to variations in the Blue Cross and/or Blue Shield Licensee medical practice protocols, you may receive benefits for some health care services obtained outside the Service Area, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the Service Area. But in no event will you be entitled to benefits for health care services that are specifically excluded or limited from coverage under this Licensee.

If you see a provider that is not a Preferred Plan or participating provider with an on-site Blue Cross and/or Blue Shield Licensee, you must submit your own claims. See the "How To Submit Other Claims" provision for information on how to file claims under these circumstances.

"Licensee" means an entity licensed by the Blue Cross and Blue Shield Association to use the Blue Cross® and/or or Blue Shield® Service Marks. A Licensee may be a Primary Licensee or its licensed affiliate, or other entity that is licensed by the Association to use Marks outside the United States.

BlueCard Worldwide®: The Company participates in BlueCard Worldwide. With BlueCard Worldwide, you have access to inpatient and outpatient hospital care and physician services when you're traveling or living outside the United States, as well as medical assistance and claims support services.

When you need health care outside of the United States or its territories, follow these simple steps:

- Always carry your current identification card.
- If you need emergency medical care outside the United States, go to the nearest hospital.
- If you are admitted, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.

- For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide hospital or make an appointment with a physician. BlueCard Worldwide Service Center staff are available to assist you 24 hours a day, 7 days a week.
- You will only be responsible for out-of-pocket expenses such as any applicable deductible, copays, coinsurance and non-covered services for your inpatient care at a participating hospital upon notification of the BlueCard Worldwide Service Center. For inpatient hospital care, outpatient hospital care or physician services by a Recognized provider, you will be responsible for paying the hospital or physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide Service Center for reimbursement of covered services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide program at www.bcbs.com.

HOW TO SUBMIT OTHER CLAIMS

When a provider or hospital does not bill the Company directly, you must submit your own claims to the "All Correspondence" address listed in the Customer Service Directory. In that situation, be sure to request two copies of the itemized bill and submit the following information to the Company:

- Subscriber's name, address, identification number, and group name and number.
- Patient's name and birth date.
- Diagnosis or nature of illness or injury and itemized bills including amount and date of each item on the physician's, facility's or other provider's letterhead or statement showing the provider's tax identification number.
- For medical equipment and supplies, also include the date of purchase, or beginning and ending dates of rental; supplier's tax identification number; name of referring provider; whether initial purchase or replacement and why replaced. A signed authorization from the provider is also required specifying duration of need.

All claims must be submitted within 12 months of the date of service. Claims not submitted within this time limit will not be paid.

RECOVERY OF PAYMENT

Payment of a claim due to error or incomplete or inaccurate information does not constitute a waiver by the Company of any provisions, limitations, or exclusions of this plan, or a waiver of the Company's right to recover such payment when the error is discovered or when complete or accurate information is received.

BENEFITS NOT TRANSFERABLE

Only you are entitled to benefits under this plan. These benefits are not assignable or transferable to anyone else and you (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits to any person, corporation, or entity. Any attempted assignment, transfer, or delegation of benefits shall be deemed null and void and will not be binding on the Company. No member may assign, transfer, or delegate any right of representation or collection other than to legal counsel directly authorized by the member on a case-by-case basis.

CHECKUP HOTLINE

We are confident that the vast majority of our subscribers and providers are careful to ensure the accuracy of their health care claims. However, we also know that irregularities can occur, sometimes intentionally. And this means higher costs for all of us for coverage and health care. Use the **CHECKUP Hotline** to report suspected fraud or abuse in the use of your health care benefits; the number is 1-800-922-4325. Call to report such things as: an ineligible person using someone else's ID card; charges that don't reflect actual treatment; a person sending in false claims for services; or someone using false eligibility information. Your call will be held in strict confidence. Please help us to hold down health care costs.

APPEALS AND GRIEVANCES

If you have a complaint against the Company or if the Company has notified you in writing that a claim or request for services or supplies has been denied, you or your authorized representative may request a review of the complaint or denial by calling or writing the Member Service Specialist at the Company within 180 days after you have received notice of the denial or the action which led to the complaint. If you have any questions, you may call the Company at the number listed in the Customer Service Directory. Although we will accept an appeal made by phone, it is preferable to put appeals in writing. You have the right to submit comments, documents, and other

information to support your appeal. You or your authorized representative may review pertinent documents at the Company. Please send all written appeals to the address shown below.

Regence BlueShield
Attn: Member Service Specialist
Post Office Box 21267
1800 Ninth Avenue
Seattle, WA 98111-3267

First Step: The Complaint or Appeal

- A Member Service Specialist will log your complaint or appeal and will send an acknowledgement letter within five business days of receiving the request.
- A Member Service Specialist, who was not involved in the initial decision, will work with a Medical Director and other Company departments, as needed, to investigate the complaint or appeal.
- The Member Service Specialist makes a decision, records it in writing, and sends a decision to you within 14 days of first receiving your complaint or appeal unless we notify you that an extension is necessary to complete the complaint or appeal; however, the extension cannot delay the decision beyond thirty days of the complaint or request for appeal, without your informed written consent. You will receive a decision regarding investigational medical procedures within 20 working days and that period cannot be extended without your informed written consent. See the definition of investigational service or supply for additional information on procedures. Decisions regarding a service that your provider wants for you but needs approval from the Company to perform will be received within 14 days.
- If you do not agree with the decision reached in the First Step review process, you may appeal the Company's decision in writing or verbally, within 180 days of receiving the decision notification. You may submit written materials supporting your appeal and may appear in person.

Second Step: Internal Appeal

- An Appeal Coordinator (Registered Nurse) working as part of a "panel," accepts and logs your appeal and notifies you within five days that it was received.
- Panel members who have not been involved in any previous decisions made regarding your original complaint or appeal will investigate your appeal.
- The panel will make a decision on the appeal, record it in writing, and will send it to you by certified mail within 14 days of receiving your appeal unless we notify you that an extension is necessary

to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without your informed written consent. You will receive a decision regarding investigational medical procedures within 20 working days and that period cannot be extended without your informed written consent. Decisions regarding a service that your provider wants for you but needs approval from the Company to perform will be received within 14 days.

- If you do not agree with the decision reached in the Second Step review process, you may ask (in writing or verbally) for an external appeal within 180 days of receiving the decision notification.

Optional Third Step: External Appeal (IRO)

- An Appeal Coordinator accepts and logs your appeal and notifies you within five days that it was received. The Appeal Coordinator also gathers all facts and supporting documents together with the previous internal appeal packet and delivers it to an Independent Review Organization (IRO) within three days of receiving your request for an external appeal.
- An IRO, made up of physicians not associated with the Company, new to the case, and with medical training in the area of your appeal, reviews your case, makes a decision, and then records it in writing and sends it to the Company.
- The Appeal Coordinator will notify you by certified mail within 30 days of receiving your appeal request.
- You may also ask for an independent review if we do not give you our First or Second Step Review decision within the time limits stated.

If you request an independent review of the Company's denial of services due to the Company's modifying, refusing, or terminating services previously covered, and the Company's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the Company will continue to provide for those services until the determination by the IRO is completed. If the determination by the IRO agrees with the Company's denial, you will be responsible for the cost of the continued health service that was paid for under this provision.

Expedited Appeals: If your treating provider determines that your health could be jeopardized by waiting for a decision under the standard process, he or she may specifically request an expedited appeal. The "panel" is new to the case and will make a decision in 72 hours. If you are not satisfied with that decision, you may ask for an expedited, second level appeal similar to the External Process described above. The IRO will make a decision within 72 hours.

WHAT ELSE DO I NEED TO KNOW?

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Coverage under the plan will not be provided for any medical (or dental and vision, if applicable) or prescription drug expenses you incur for treatment of an injury or illness if the costs associated with the injury or illness may be recoverable from any of the following:

- A third party;
- Worker's compensation; or
- Any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to you, whether or not you make a claim under such coverage.

Advancement of Benefits: If you have a potential right of recovery for illnesses or injuries from a third party who may have legal responsibility or from any other source, benefits may be advanced pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, you agree that the plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the injury or illness for which benefits under the plan have been provided.
- In addition to the plan's right of reimbursement, the Company may choose instead to achieve the plan's rights through subrogation. The Company is authorized, but not obligated, to recover any benefits paid under the plan directly from any party liable to you, upon mailing of a written notice to the potential payer, to you or to your representative.
- The plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the member and/or any third party or the recovery source. The plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
  1) The third party or third party's insurer admits liability;

   2) The health care expenses are itemized or expressly excluded in the recovery; or
   3) The recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the plan.
- Reimbursement or subrogation under the plan will not be reduced due to your not being made whole.
- You may be required to sign and deliver all legal papers and take any other actions requested to secure the plan's rights (including an assignment of rights to pursue your claim if you fail to pursue your claim of recovery from the third party or other source). If you are asked to sign a trust agreement or other document to reimburse the plan from the proceeds of any recovery, you will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice the plan's rights and that you will cooperate fully with the Company, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Company of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
   1) The filing of a lawsuit;
   2) The making of a claim against any third party;
   3) Scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
   4) Intent of a third party to make payment of any kind to your benefit or on your behalf and that in any manner relates to the injury or illness that gives rise to the plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and/or your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to your benefit or on your behalf that in any manner relates to the injury or illness giving rise to the plan's right of reimbursement or subrogation, until the plan's right is satisfied or released.
- In the event you and/or your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any illness or injury may be recovered through legal action.
- Any benefits provided or advanced under the plan are provided solely to assist you. By paying such benefits, neither the plan nor the Company is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage: If you are involved in a motor vehicle accident, you may have rights both under motor vehicle insurance

coverage and against a third party who may be responsible for the accident. In that case, this right of reimbursement and subrogation provision still applies.

Workers' Compensation: Here are some rules which apply in situations where a workers' compensation claim has been filed:

- You must notify the Company in writing within five days of any of the following:
  1) Filing a claim;
  2) Having the claim accepted or rejected;
  3) Appealing any decision;
  4) Settling or otherwise resolving the claim; or
  5) Any other change in status of your claim.
- If the entity providing workers' compensation coverage denies your claim and you have filed an appeal, benefits may be advanced for covered services if you agree to hold any recovery obtained in a segregated account for the plan.

Fees and Expenses: Neither the plan nor the Company is liable for any expenses or fees incurred by you in connection with obtaining a recovery. However, you may request that a proportional share of attorney's fees and costs be paid at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the plan. The Company has discretion whether to grant such requests.

Future Medical Expenses: Benefits for otherwise covered services may be excluded, as follows:

- When you have received a recovery from another source relating to an illness or injury for which benefits under the plan have been previously paid.
- Until the total amount excluded under this provision equals the third-party recovery.

The amount of any exclusion under this provision, however, will not exceed the amount of benefits previously paid in connection with the illness or injury for which the recovery has been made.

INDIVIDUAL BENEFITS MANAGEMENT

For certain illnesses or injuries, our Individual Benefits Management staff will work with you and your provider to determine the treatment options that will provide the most cost-effective or beneficial care in your specific case. In some instances, the Individual Benefits Management staff may authorize benefits that would not normally be covered under this plan; such authorization must be received in

advance of the service being provided. The final decision on the course of treatment will rest with you and your provider.

When provided at equal or lesser cost, the benefits of this plan, including home medical equipment provided by a home health or hospice agency, will be available for home health care instead of hospitalization or other inpatient care when furnished by a licensed home care agency or by a home health or hospice agency that is covered under this plan. Substitution of less expensive or less intensive services will be made only with your consent and when recommended by your physician or health care provider and will be based on your individual medical needs. A written treatment plan may be required by the Company. Coverage will be limited to the maximum benefit payable for hospital or other inpatient expenses under this plan and will be subject to any applicable deductible, coinsurance and plan limits. These benefits will only be provided when your condition is serious enough to require inpatient care and you could qualify for the inpatient benefits of this plan; no benefits will be provided for custodial care.

COORDINATION OF BENEFITS

Coverage under another group or individual plan

Many people subscribe to more than one group or individual health care plan in order to protect themselves against the high costs of medical care. To keep the cost of your health care benefits as low as possible, the Company will coordinate benefit payments with your other group or individual health care plans so that you will receive up to, but not more than actual expenses for covered benefits. This prevents people from collecting more than the actual cost of services, which can substantially increase rates.

If you or your dependents are covered under another group or individual plan, it is your responsibility to make sure that identical, itemized bills are submitted to both carriers at the same time. The Company and your other carrier will determine payment.

If the other plan does not contain a coordination of benefits provision, that plan will pay first. When this plan is the primary plan for medical coverage, benefits will be paid by this plan as if there were no coordination of benefits. Whenever another group plan is primary, then this plan will pay only the difference between the benefits paid by the primary plan and what would have been paid had this plan been primary. If the other plan contains a coordination of benefits provision, the following rules will determine payment:

1. The plan covering you as a subscriber will pay first.

2. The plan covering you as the dependent of a subscriber whose day and month of birth occur earlier in the calendar year will pay before the plan covering you as the dependent of a subscriber whose day and month of birth occur later in the calendar year; except that, if the other plan does not contain this rule, resulting in conflicting orders of benefit determination, the other plan's provisions will apply. However, if a dependent child's parents are separated or divorced, the following will apply:
   - If the parent with custody has not remarried, the plan of the parent with custody will pay before the plan of the parent without custody.
   - If the parent with custody has remarried, the benefits of the plans that cover the child will be determined in the following order: plan of the parent with custody; plan of the spouse of the parent with custody; plan of the parent without custody; plan of the spouse of the parent without custody.
   - However, if the court decree establishes financial responsibility for the health care of the child, the benefits of the plan that covers the child as the dependent of the parent with such financial responsibility will be determined first.
3. If none of the above rules establish which plan pays first, the benefits of the plan that has covered you for the longer period of time will be determined first. However, for a retired or laid-off subscriber and his or her dependents, the benefits of this plan will pay after the benefits of any other plan covering such person as an active employee or dependent except that, if the other plan does not have a provision regarding retired or laid-off employees, resulting in each plan determining its benefits after the other, this plan's provision for retired or laid-off subscribers will not apply.
4. If none of the above rules establish which plan pays first, the benefits of the plan that has covered the subscriber for the longer period of time will be determined first.

In no event will you recover under this plan and all other plans combined more than the total allowable actual expenses of benefits offered by this plan and the other plans. Nothing contained in this section shall entitle you to benefits in excess of the total maximum benefits of this plan during the claim determination period. You shall refund to the Company any excess it may have paid.

If a payment that should have been made under this plan was made by another plan, the Company has the right, exercisable alone and in its sole discretion, to pay to the other plan any amount the Company determines is necessary to satisfy the provision of this section. Any amount paid shall be considered benefits under this plan, and, to the extent of such payments, the Company shall be fully discharged from liability under this plan.

Whenever payments have been made by the Company in excess of the maximum amount of payment necessary to satisfy the provisions of this section, the Company shall have the right to recover such excess payments from you, the provider, and the other plan.

COVERAGE UNDER A PRIOR PLAN

If you were covered under another plan underwritten or administered by the Company for your group before coverage under this plan began, the following will apply:

- Any benefits (except mental disorder benefits) used under a prior plan during that calendar year will be charged against this plan's maximums for that same calendar year. Benefits for mental disorders used under a prior plan during that calendar year will be charged against this plan's maximum for extended network benefits for mental disorders, if any. Any benefits used under a prior plan and not reinstated will also be charged to the benefit maximums of this plan.
- You will be allowed to credit your stoploss accumulation against your new stoploss limit for Selections network benefits during the same calendar year.
- You will be allowed to credit your eligible deductible expenses accumulated during a calendar year or during the last three months of the prior calendar year to your new deductible.

TERMINATION OF COVERAGE

Termination of Subscriber or Dependent Coverage: Coverage under this plan will terminate for a subscriber or dependent immediately as follows:

- When the group plan terminates as specified in the ASC Administrative Services Agreement, coverage will end on the date of termination.
- When the rate is not received as specified in the ASC Administrative Services Agreement, coverage will cease at the end of the last calendar month for which timely payment was received.
- When you are no longer eligible for coverage or leave the group, coverage will cease at the end of the same calendar month.
- When there is legal cause for termination, coverage will cease on the date of written notice.

If coverage under this plan terminates for a subscriber, it will also cease for the subscriber's dependents. However, you may be eligible for an extension of group benefits as described below. The extension

of coverage will end when your group's Agreement with the Company terminates.

Certificate of Health Coverage: When your coverage under this plan ends, the Company automatically will send you a "Certificate of Health Coverage." The Company will also issue a certificate, upon your request, within 24 months of cessation of coverage. The certificate will provide information about your length of coverage under this plan. Please verify the accuracy of the information when you receive your certificate. If you do not receive a certificate or misplace the one you receive, please contact the Company at Post Office Box 21267, Seattle, WA 98111-3267.

COBRA: The provisions of this plan will be subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for groups that normally employed 20 or more employees during the previous calendar year and that are required by federal law to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Contact your employer for information on a COBRA continuation of coverage.

- Continuation coverage under this plan will be provided to a person entitled to such coverage under COBRA, when all requirements of COBRA, such as timely notices, have been complied with.
- Your group must notify the Company of your election of COBRA continuation coverage within 60 days after the election, provided that all notice requirements of COBRA have been met in a timely manner. Your failure to make timely election will constitute a waiver of your rights to COBRA continuation coverage under this plan. Failure to provide timely notices may not, in all cases, terminate your right to continuation coverage; however, such failure will eliminate any obligation of the Company to provide continuation coverage under this plan.
- If you become entitled to Medicare or covered under another group health plan after the date of COBRA election, you will not be eligible for COBRA continuation unless the other plan limits or excludes coverage for a preexisting condition you have. In such a case, you will not be eligible for COBRA continuation once that preexisting condition is covered.

If you elect a COBRA continuation of coverage, you will no longer be entitled to any other extension of coverage that may be available under your plan as explained in this brochure.

You or your dependents may be responsible for payment of the group rates during an extension of coverage. Payment must continue to be submitted through your group representative. The right to an

extension of coverage will end when your group's Agreement with the Company terminates.

See "When You Are No Longer Eligible For Coverage" for information on conversion plans when your COBRA continuation ends.

Leave of Absence: The time allowed for a leave of absence is different for each leave category (e.g. military leave, personal leave, dependent care leave, disability leave, etc.). A complete list of leave of absence categories and their respective time limits and requirements are available by request from the Human Resource Department.

Six-Month Extension: If your group is not eligible for COBRA or if you do not qualify for a COBRA continuation for any reason, you are eligible for a six-month extension, provided the rates are paid when due through your group representative as specified in your Agreement. This extension does not apply for employees whose employment was terminated for misconduct.

Leaves Under the Family and Medical Leave Act (FMLA): The FMLA applies only to groups that employed 50 or more employees during each of the 20 or more calendar workweeks in the current or preceding calendar year and that are required by federal law to comply with FMLA provisions. Under this provision, eligible subscribers may receive up to 12 weeks of leave during a 12-month period, as provided by FMLA, under the following circumstances:

- The birth of the subscriber's child.
- The placement of a child with the subscriber for adoption or foster care.
- Care for the subscriber's seriously ill spouse, parent or child.
- The subscriber's own serious physical or mental health condition.

Eligible subscribers and their covered dependents may continue coverage under this plan. Persons who are entitled to a FMLA leave will not be entitled to the leave of absence or to the six-month self-pay extension for the same situation. Please contact your employer for more detailed information on FMLA leaves.

PAYMENT OF RATES DURING A LABOR DISPUTE

If your compensation is discontinued due to a labor dispute, you may continue coverage during the dispute for as long as six months provided the rates are paid when due as specified in the Agreement. Your payments must continue to be submitted through your group. The six months of coverage provided to you under the labor dispute rule above will begin at the same time as any applicable COBRA continuation. If you are eligible for the continuation of coverage

provision of COBRA, this labor dispute rule will not apply. Contact your employer for more information.

Cessation of Benefits: No person has a right to receive benefits of this plan after the date this plan terminates. Termination of your coverage under this plan for any reason completely ends all obligations of the Company to provide you with benefits for services or supplies received after the date of termination whether or not you may be receiving treatment, or may need further treatment, for any illness, injury, or physical disability incurred or treated before or while this plan was in effect.

WHEN YOU ARE NO LONGER ELIGIBLE FOR COVERAGE

If you or any of your dependents are no longer eligible for coverage under this plan, health protection with the Company is available as described below. If coverage under this plan terminates for your entire group and the group transfers its plan to another contract with the Company, to another carrier or to another self-insured plan and you or your dependents become covered under the new plan, the conversion options described below do not apply.

Medicare Supplement: Persons who are eligible for Medicare may be eligible for coverage under one of the Company's Medicare Supplement plans. To be eligible for continuous coverage, the Company must receive the person's application within 31 days following termination of coverage under this plan. If a person applies for Medicare Supplement coverage within six months of enrolling in Medicare Part B coverage, no health statement will be required. After the six-month enrollment period, a health statement may be required. Benefits and rates under the Medicare Supplement plan will be substantially different from this plan.

Conversion Plan: For persons under age 65 who are not eligible for Medicare, coverage will be available under one of the Company's conversion plans. To be eligible, the Company must receive the person's application within 31 days after termination of coverage under this plan. A health statement will not be required. The benefits of the conversion plan will be the standard individual medical and hospital benefits then being issued by the Company for people converting from another plan; rates will be higher than for this plan, and benefits may be substantially less. The benefits under the conversion plan will not be subject to any waiting periods of this plan as described in this brochure. However, any new dependents added to the conversion plan after the subscriber's effective date will have to satisfy the waiting periods of the conversion plan. By enrolling on a conversion plan, you

may lose the right to enroll under one of the Company's marketed individual plans without submitting a health questionnaire.

Individual Plan: Instead of applying for one of the conversion plans described above, a person not eligible for Medicare may also apply for coverage under one of the Company's marketed individual plans. To be eligible, the person must submit a completed application form and health questionnaire, if applicable, and must be accepted by the Company for coverage. Benefits and rates under the individual plan may be substantially different from this plan.

Leaving Our Service Area: If you move to an area served by another Blue Cross and/or Blue Shield Plan, your coverage may be transferred to the Plan serving your new address. The other Blue Cross and/or Blue Shield Plan must offer you at least its conversion contract, which does not require a medical examination or health statement. If you accept the new conversion contract, you will receive credit for the length of your enrollment with our Company toward any of the new Plan's waiting periods. The rates and benefits available from your new carrier may vary significantly from those offered by our Company.

You may also be offered other types of coverage with the Blue Cross and/or Blue Shield Plan serving your new location; please be aware that such contracts may require a medical examination or health statement to exclude coverage for preexisting conditions, and may not apply time enrolled with our Company to the new waiting periods. Contact our office when you are leaving our service area and we will assist you in transferring to a Blue Cross and/or Blue Shield Plan in your new location.

RELEASE OF MEDICAL INFORMATION

As a condition of receiving benefits under this plan, you and your dependents waive any claim of privilege or confidentiality that might be asserted in any action by or against the Company or the party furnishing such information, except in cases of negligent or irresponsible use of the information by the Company and authorize:

- Any provider to disclose to the Company any medical information it requests in accordance with state and federal law.
- The Company to examine your medical records at the offices of any provider.
- The Company to release to or obtain from any person or organization any information necessary to administer your benefits.
- The Company, in the exercise of its subrogation rights, and persons acting on behalf of the Company to release any

information about an accident, your injuries, and the benefits and medical services you received to any person who may be liable to you or to the Company, and to such person's insurer.
- The Company to examine your employment records in order to verify your eligibility.

The Company will keep such information confidential whenever possible, but under certain circumstances, it may be disclosed without specific authorization.

DEFINITIONS

We've worked hard to make your Selections plan as easy as possible to understand and use. One way is by giving you clear definitions of terms you may encounter as you use your plan.

Agreement: As constituted by the ASC Administrative Services Agreement, the Addendum, and this brochure, the agreement between the group and the Company that controls the terms and conditions of this plan.

Allowed Amount: The allowed amount shall mean one of the following:

- ***Selections, Preferred Plan, or Participating Providers Inside The Service Area, Who Have Agreements With The Company:*** For services or supplies covered under this plan, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between the Company and the provider. These providers agree to seek payment from the Company when they furnish covered services to you. You will be responsible only for any applicable deductible, copays, coinsurance, and charges in excess of the stated benefit maximums, if any, and for charges for services and supplies not covered under this plan.
- ***Preferred Plan or Participating Providers Outside The Service Area Who Have Agreements With Other Blue Cross and/or Blue Shield Licensees:*** The allowed amount is determined as stated in the Outside The Service Area provision of the "How Do I File A Claim?" section.
- ***Recognized Providers Who Do Not Have Agreements With The Company Or Another Blue Cross and/or Blue Shield Licensee:***
  1) Inside the service area, the allowed amount will be equivalent to billed charges.
  2) When services outside the service area are not received through the BlueCard program, the allowed amount is determined, at the Company's option, as either the billed charge passed by the Blue Cross and/or Blue Shield Licensee in that area or an amount determined by an independent entity selected by the Company.
  3) When you seek services from providers that do not have agreements with the Company, your liability is for any amount above the allowed amount, and for any applicable deductible, coinsurance, copays, amounts in excess of stated benefit maximums, if any, and charges for services and supplies not covered under this plan.

The Company reserves the right to determine the amount allowed for any given service or supply.

You will be responsible for the total billed charges for services or supplies in excess of lifetime or per calendar year benefit maximums, if any, and for charges for any other service or supply not covered under this plan, regardless of the provider rendering such service or supply.

Benefits: Payment by the Company for services and supplies covered under this plan.

Chemical Dependency: An illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under RCW 69.50 and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Coinsurance: The percentage share payable by you on claims for which the Company provides benefits at less than 100% of the allowed amount.

Company: Regence BlueShield.

Copay: The amount, in addition to the rate, you are required to pay for certain services and supplies provided under this plan. The copay will be the copay amount as stated in the "What Do I Have To Pay For?" and "Benefits" sections of this plan, or the allowed amount, whichever is less. You are responsible for the payment of any copay directly to the provider of the service or supply.

Cosmetic: Services and supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance.

Custodial Care: Care that, as determined by the Company, is designed primarily to assist you in activities of daily living, and which is not primarily provided for its therapeutic value in treatment of an illness or injury, including institutional care that serves primarily to support self-care and provide room and board, and can be provided by people without medical or paramedical skills. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of meals or special diets, and supervision of medications that are ordinarily self-administered.

Dental Services: Services and supplies (including drugs) provided to diagnose, prevent, or treat diseases or conditions of the teeth and supporting tissues, including treatment that restores the function of the teeth.

Dependent: A person listed on the subscriber's application as a dependent of the subscriber, who is eligible, and for whom the Company has received an application for dependent coverage as stated in the "When Am I Eligible For Coverage?" section and has been accepted by the Company for dependent coverage, and for whom the applicable rate has been paid.

Extended Network Benefits: The level of benefits available when you do not have your care provided by or coordinated through your Personal Care Provider, unless specifically stated otherwise in the "Benefits" section.

Group: The body named on the cover page of the ASC Administrative Services Agreement as a party to this plan with the Company and whose members are eligible for subscriber or dependent coverage as stated in the "When Am I Eligible For Coverage?" section.

Hospital: An accredited general hospital that is a provider covered under this plan.

Inpatient: A person confined overnight in a hospital or other facility as a regularly admitted bed patient to whom a charge for room and board is made in accordance with the hospital's or facility's standard practice.

Inpatient Rehabilitation Admission: An inpatient admission to a Company approved facility specifically for the purpose of receiving speech, physical, or occupational therapy in an inpatient setting.

Investigational Service Or Supply: A service or supply (including but not limited to drugs, devices, and other items) that is determined by the Company to be either: classified as experimental and/or investigational by the national Blue Cross Blue Shield Association or the Company, or is on an investigational protocol, unless approved in writing in advance by the Company.

The national Blue Cross Blue Shield Association's determination is based on the following criteria:

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes (which means significant measurable improvement in length of life, ability to function, or quality of life);
- The technology must improve the net health outcome (as defined above);

- The technology must be as beneficial as any established alternatives;
- The improvement must be attainable outside the laboratory or clinical research setting; and
- Items must have been approved by the U.S. Food and Drug Administration (FDA) as being safe and efficacious for general marketing, and permission must have been granted by the FDA for commercial distribution.

If the Company receives a fully documented claim or request (see below) for preauthorization related to a service, supply, drug, device, or other item, a decision will be made and communicated to you within 20 working days. If a decision is made to deny benefits, the written denial will identify (by name and job title) the individual making the decision. The written denial will contain the basis for the decision and an explanation of your right to appeal the decision.

You may also have a right to an expedited appeal. See the Appeals and Grievances provision in the "How Do I File A Claim?" section for additional information on procedures.

"Fully documented" means that all of the following are included with your claim or request:

- A hard copy of your clinical history.
- All reasonably available relevant medical literature (including peer-reviewed articles) that support or relate to the claim or request.
- If your request is for a drug or supply, the booklet describing its function, indications, and FDA approval notification. If the drug is not FDA-approved for a specific condition, documentation showing whether the drug is Group A, B, or C, with supporting documentation.
- If the treatment or procedure is part of a research protocol, copies of the research protocol and any informed consent that you have signed or will be asked to sign in connection with the treatment or procedure that is the subject of the claim or request, and copies of all documents created by the institutional review board of the institution where the treatment or procedure will be performed that relate to the treatment or procedure, including all supporting documentation.

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.)

Medically Necessary: The health care services or supplies that a physician or other health care provider exercising prudent clinical judgment, would provide to a member 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 member's illness, injury or disease; and
- Not primarily for the convenience of the member, physician or other health care provider, and not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's illness, injury or disease.

For these purposes, "generally accepted standards of medical 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: The subscriber or dependent.

Mental Disorders: Only those diagnoses included in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, (except as specified in the Chemical Dependency Benefit and except as otherwise excluded under this plan), regardless of the cause of the disorder, including whether or not the condition has an organic/physiologic or a functional basis.

Off-Label: The prescribed use of a drug which is other than that stated in its FDA-approved labeling.

Participating Provider:

- Inside the service area, a provider whose name is included in the current list of participating providers for this plan as prepared by the Company and provided to the group and who has entered into a current participating agreement with the Company.
- Outside the service area, a provider who has entered into a current participating agreement with the local Blue Cross and/or Blue Shield plan and who is acting within the scope of that provider's license, who belongs to a category of providers whose services or supplies would be covered under this plan as benefits if furnished inside the service area.

Peer-Reviewed Medical Literature: Scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.

Personal Care Provider: A Selections provider whose name is included in the current list of Selections Personal Care Providers for this plan as prepared by the Company and provided to the group and who has entered into a current Selections Personal Care Provider agreement with the Company.

Physician: A licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.), or a licensed doctor of naturopathic medicine (N.D.), who is a provider covered under this plan.

Preferred Plan Provider:

- Inside the service area, a provider whose name is included in the current list of Preferred Plan providers for this plan as prepared by the Company and provided to the group and who has entered into a current Preferred Plan provider agreement with the Company.
- Outside the service area, a provider who has entered into a current Preferred Plan provider agreement with the local Blue Cross and/or Blue Shield plan and who is acting within the scope of that provider's license, who belongs to a category of providers whose services or supplies would be covered under this plan as benefits if furnished inside the service area.

Prescription Drug: Inside the United States, any state or federal legend drug approved by the Food and Drug Administration (FDA), including compounded products with active ingredients approved by the FDA requiring a prescription, and dispensed by a licensed pharmacist. Outside the United States, any drug equivalent to a state or federal legend drug approved by the FDA.

Recognized Provider:

- Inside the service area, a provider who is acting within the scope of that provider's license, who belongs to a category of providers to whom Selections, Preferred Plan, or participating provider agreements are not offered but for whose services this plan provides certain benefits only as specified in the Payment Schedule.
- Outside the service area, a provider who is acting within the scope of that provider's license, who belongs to a category of providers that do not have Preferred Plan or participating provider

agreements with Blue Cross and/or BlueShield Licensees, other than the Company, but whose services or supplies would be covered under this plan as benefits if furnished inside the service area. The recognized provider must have qualifications and a license or certification required for the comparable provider category inside the service area.

- For medical emergencies, inside or outside the service area, a recognized provider means a provider who is not a Selections, Preferred Plan, or participating provider.

Reconstructive: Services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but it may also be done to approximate a normal appearance.

Selections Network Benefits: The level of benefits available when your care is given by or coordinated through your Personal Care Provider. You must notify the Company which Personal Care Provider you have selected before you will be eligible for Selections network benefits. Selections network benefits are also provided when you self-refer for certain services. See the "Benefits" section for more information.

Selections Provider: A provider whose name is included in the current list of Selections providers for this plan as prepared by the Company and provided to the group and who has entered into a current Selections provider agreement with the Company.

Service Area: Washington counties of King, Pierce, Snohomish, Lewis, Cowlitz, Wahkiakum, Thurston, Yakima, Walla Walla, Grays Harbor, Pacific, Clallam, Columbia, Mason, Jefferson, Kitsap, Klickitat, Skagit, Whatcom, Skamania, San Juan, Island; and any other areas designated by the Company. Please check our Web site at www.wa.regence.com for up-to-date information.

Standard Reference Compendia:

- The American Hospital Formulary Service-Drug Information;
- The American Medical Association Drug Evaluation;
- The United States Pharmacopoeia-Drug Information; or
- Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

Stoploss: The dollar limits of coinsurance amounts that you are responsible to pay during a calendar year. After you have reached a stoploss limit, the Company will pay most benefits within that stoploss category at 100% of the allowed amount for the remainder of

the calendar year. Some benefits are not subject to the stoploss provision, as specified in the "Benefits" section; these benefits will always remain payable at the percentage level given in the Payment Schedule or in the applicable benefit section. **In addition, the following do not count toward the stoploss: your annual deductible; any copays; any coinsurance required when the preadmission approval provision is not satisfied; and any balances that remain after benefit limits have been expended.**

Subscriber: An individual member of the group who is eligible for subscriber coverage as stated in the "When Am I Eligible For Coverage?" section.

Year: Calendar year (January 1 through December 31).

CUSTOMER SERVICE DIRECTORY

Customer Service Number: Please use the following phone number and address when you need to contact the Company regarding general information about your health plan benefits or to submit medical claims. For the most up-to-date list of Selections, Preferred Plan, and participating providers and our service area, please go to our Web site at www.wa.regence.com. If you have questions on the second surgical opinion process or the preadmission approval process, simply call the phone number specified below. Please read the "What Do I Need To Do Before I Get Care?" section for more details.

Toll Free 1-800-458-3523
TTY 1-877-727-4357

ALL CORRESPONDENCE
Regence BlueShield
Post Office Box 21267
1800 Ninth Avenue
Seattle, WA 98111-3267

For Chemical Dependency or Mental Disorders Benefits, if any, call the Company at: 1-800-780-7881.

Notices: Any notices under this plan shall be deemed given when deposited in the United States mail, with postage prepaid, addressed to the group representative at his or her last address appearing in the records of the Company, or addressed to the Company at the address listed below.

Regence BlueShield
Post Office Box 21267
Seattle, WA 98111-3267

WOMEN'S HEALTH AND CANCER RIGHTS

If you are receiving benefits in connection with a mastectomy and you, in consultation with your attending physician, elect breast reconstruction, we will provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Reconstruction benefits are subject to the same provisions as any other benefit provided under this plan (e.g., deductibles, copayment and/or coinsurance, and maximum coinsurance).

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

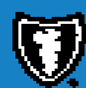
Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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

1800 Ninth Avenue
Seattle, Washington 98101-1322

For more information,
call 1 (206) 464-3663 or
toll-free 1 (800) 458-3523

www.wa.regence.com



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