Preferred Plan

A Quick and Easy Guide to Benefits

Asuris Northwest Health Preferred Plan **80/80/50/25**

Progressive 650

065016-81257 B

Effective October 1, 2008

TABLE OF CONTENTS

When Am I Eligible For Coverage? **3**

What Do I Need To Do Before I Get Care? **6**

What Do I Do When I Need Care? **9**

What Do I Have To Pay For? **11**

Benefits **17**

When Won't Things Be Covered? **35**

How Do I File A Claim? **42**

What Else Do I Need To Know? **47**

Definitions **58**

Customer Service Directory **64**

This brochure is a **summary** of the benefits available under the Contract. For complete details on Contract provisions, please refer to the Contract on file with your group.

WELCOME HOW CAN WE HELP YOU?

At Asuris Northwest Health, we believe in providing the highest quality customer service. This means that we offer top-notch benefit plans, a broad choice of providers and hassle-free health care, with local customer service staff who can answer your questions quickly and accurately. Providing coverage since 1933, we stand by our original goal: to be the first choice in health plans for eastern Washington.

INTRODUCTION

Your Preferred Plan is designed to provide benefits for high-quality health care rendered in the most appropriate setting. This plan provides coverage for subscribers and dependents enrolled with Asuris Northwest Health.

The “preferred plan” concept allows you a wide choice of health care providers who have agreed to accept a negotiated fee for their services to you. To obtain the highest level of benefits, you must receive services from a Preferred Plan provider. The Payment Schedule shows the benefit payment levels for your Preferred Plan. Please read the brochure carefully, so that you will be familiar with all the provisions that apply to your plan, including any limitations and exclusions.

In addition, your plan contains special provisions to help you choose the most appropriate and cost-effective level of care. If you have any questions about your benefits, please call the number listed in the Customer Service Directory.

In this brochure, Asuris Northwest Health is referred to as the “Company” and the Asuris Northwest Health Preferred Plan is referred to as the “Preferred Plan.”

This plan is underwritten by Asuris Northwest Health of Seattle, Washington.

WHEN AM I ELIGIBLE FOR COVERAGE?

EMPLOYEE ELIGIBILITY

Active, full-time employees of the group are eligible for coverage under this plan. In this brochure, the employee is referred to as the "subscriber."

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), and dependent on the subscriber, spouse, or non-covered legal parent for total or partial support. 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 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. Proof of the incapacity and dependency will be required within 31 days after the child's 25th birthday, and not more frequently than one time per year after the child's 27th birthday. 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 accepted 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 for 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 accepted 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 accepted 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. For the subscriber's natural newborn, adoptive child under age 18, or child placed for adoption under age 18, none of the preexisting limitations or preexisting condition waiting periods of this plan will apply to such child, if enrolled for coverage under this plan within 60 days of birth, adoption, or placement for adoption. If your group's Contract 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.

WHAT DO I NEED TO DO BEFORE I GET CARE?

Your Preferred Plan includes a health management program to encourage you to be aware of and involved in decisions about the most cost-effective level of medical care that is appropriate for you. There are frequently less costly alternatives to more expensive medical procedures or settings.

Please read the following sections on second surgical opinions and preadmission approval carefully. If you do not follow the procedures, your benefits could be significantly reduced. Benefits for these procedures are subject to waiting periods, the 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 charges will be paid in full for the second opinion and are not subject to any deductible or copay when performed by the physician referred to you as described below.

Your 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.

If you are using a recognized physician or a physician outside the service area, and request a second surgical opinion, you must contact the Company at the number listed in the Customer Service Directory in order to receive full benefits for the second surgical opinion.

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

Required for Care Outside the Service Area Only

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 recognized provider or a provider outside the service area, you must have your provider contact the Company prior to any inpatient facility 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 percentage specified for Preferred Plan Professional

Services in the Payment Schedule 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?

IN THE SERVICE AREA

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

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.

Within the service area, you have the choice of three categories of providers. The category you choose will affect how your benefits will be paid. In general, to obtain the highest level of benefits, you must receive care from a Preferred Plan provider. It is your responsibility to make sure you are treated by a Preferred Plan provider. Lists of Preferred Plan and participating providers are available on our Web site, from your employer or by contacting the Company at the number specified in the Customer Service Directory. No benefits will be provided unless you are under the care of one of the providers specified below.

Preferred Plan Providers: When you use the services of a Preferred Plan provider, most benefits will be paid at a higher percentage than for participating or recognized providers, as shown in the Payment Schedule, unless specifically stated otherwise. See the "Definitions" section for a definition of Preferred Plan providers. You may also call the number in the Customer Service Directory of this brochure for assistance in finding a Preferred Plan provider who can render the services you need.

Participating Providers: You may also use the services of a participating provider, as defined in the "Definitions" section. Benefits for participating providers will usually be paid at a lesser percentage than for Preferred Plan providers, as shown in the Payment Schedule, unless specifically stated otherwise.

Recognized Providers: You may also use the services of a recognized provider, as defined in the "Definitions" section. Benefits for recognized providers will be paid at the level specified in the Payment Schedule and will be based on the allowed amount.

OUTSIDE THE SERVICE AREA

Outside the service area, benefits will be provided for care received from an out-of-area provider (see the "Definitions" section) based on the allowed amount at the level specified in the Payment Schedule. You may receive benefits at the Preferred Plan provider level outside the service area if you see a Preferred Plan provider with an affiliate plan of The Regence Group. Please call the telephone number listed in the Customer Service Directory to find the Preferred Plan provider nearest you. Be sure to present your identification card when consulting a provider or receiving treatment at a hospital.

If you reside 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 Preferred Plan provider in the service area as soon as medically feasible in the opinion of the Company. If you meet all requirements, inpatient benefits will be provided at the Preferred Plan provider level.

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

Emergency Care: In the event of a medical emergency, 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. Benefits will be provided at the level specified in the Payment Schedule for a Preferred Plan provider. Please refer to the "Definitions" section for the definition of a medical emergency.

WHAT DO I HAVE TO PAY FOR?

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

COPAYS

Each covered person will be required to pay the dollar amount(s) specified below or as specified in the "Benefits" section.

A $25 copay will be applied for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department (waived for surgery, for radiation and chemotherapy, for spinal manipulations, or if you are directly admitted to the hospital as an inpatient).

Office, home, and hospital outpatient department visits will not be subject to the deductible amount when a member is responsible for a per-visit copay. Outpatient diagnostic x-ray and laboratory services are not subject to the annual deductible. Services provided by professionals that are not subject to the per-visit copay are subject to the annual deductible, unless specifically stated otherwise.

You will be responsible to pay a $150 copay for each visit to a hospital emergency room for illness, injury or surgery. This amount will be waived 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 limit.

DEDUCTIBLE

The deductible is the cost of **covered** medical expenses that you must reach and are responsible to pay before your benefits are available, unless specified otherwise. The deductible amount under this plan is $650 per covered member, per calendar year. No benefits will be provided until the deductible has been met, unless specified otherwise.

Any copays required by your plan, charges for services and supplies not covered by this plan, 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 two or more covered family members reach eligible deductible expenses totaling two 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 from a Preferred Plan or out-of-area provider prior to your discharge from the hospital if you have met the stoploss limit for

Preferred Plan provider services for the calendar year in which the hospitalization began.

STOPLOSS LIMITS

The benefits of this plan will be provided at the percentage of the allowed amount specified in the Payment Schedule. When your eligible out-of-pocket coinsurance expenses (called your stoploss limit) for Preferred Plan and out-of-area provider services, have reached $2,500 per member, per calendar year, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year, unless otherwise specified.

Services from participating or recognized providers do not apply toward the stoploss, except for services provided for Skilled Nursing Facility, Ambulance, Blood Bank and for services provided by dentists for the Temporomandibular Joint Disorders Benefit.

If two or more covered family members reach coinsurance expenses for Preferred Plan and out-of-area provider services totaling two stoploss limits in a calendar year, the stoploss requirement will be considered satisfied for all family members during that calendar year. (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 deductible and any copay requirements, benefits will be provided at the payment levels specified below or in the “Benefits” section of this brochure. Please read the entire brochure for details on these and other benefits, specific benefit limitations and maximums, waiting periods, and exclusions.

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

Benefit	Preferred Plan Provider	Participating and Recognized Provider
Professional Office Visits (Office, home, or outpatient Hospital visits that are billed as an office visit)	100%	50%
All other professional services not billed as an office visit	80% (unless specified otherwise)	50% (unless specified otherwise)

Benefit	Preferred Plan Provider	Participating and Recognized Provider
Hospital Services** (inpatient and outpatient benefits including diagnostic x-ray and laboratory services) $150 copay per emergency room visit (waived if admitted)	80%	50%
Acupuncture	80%	50%
Ambulatory Surgical Center	80%	50%
Chemical Dependency	80%	50%
Colorectal Cancer Screening	100% Professional 80% Facility	50%
Diabetes Care Training	80%	50%
Growth Hormone	80%	50%
Home Health	80%	80%
Home Medical Equipment	80%	50%
Home Phototherapy	80%	80%
Hospice	80%	80%
Hospitalization for Dental Services	80%	50%
Infusion Therapy	80%	50%
Mammography	80%	50%
Maternity	same as any condition	
Mental Disorders Inpatient and Outpatient	80%	50%
Neurodevelopmental Therapy	80%	50%
Newborn Care	80%	50%
Occupational Injury	same as any condition	
Phenylketonuria Formulas	80%	80%
Preadmission Testing for Surgery	80%	50%
Prenatal Testing	80%	50%
Prostate Cancer Screening	same as any condition	
Prostheses and Orthotics	80%	50%
Rehabilitative Services Inpatient and Outpatient	80%	50%
Skilled Nursing Facility	*	80%

Benefit	Preferred Plan Provider	Participating and Recognized Provider
Smoking Cessation	75%	75%
Special Equipment and Supplies	80%	80%
Spinal Manipulations	80%	50%
Sterilization Procedures	80%	50%
Temporomandibular Joint Disorders	80%	50%
Transplants	80%	50%

*This service is provided only by participating and recognized providers at this time. You may contact the Company for up-to-date information on Preferred Plan and participating providers.

**Services and supplies required to treat a medical emergency, inside the service area, will be provided at the Preferred Plan payment level of benefits 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	Recognized Provider
Ambulance Services	80%
Blood Bank	80%
Repair of Teeth	80%
Temporomandibular Joint Disorders (services of dentists)	80%

Benefit Payment Level for Services Provided Outside the Service Area: All care received from an out-of-area provider, whether or not a medical emergency, will be paid at 80% of the allowed amount, unless a lower percentage is specified above. Any additional charges will be your responsibility. You may receive benefits at the Preferred Plan provider level outside the service area if you see a provider for which the Company has arranged for the provision of benefits to its members as a Preferred Plan provider. Please call the telephone number listed in the Customer Service Directory to find the Preferred Plan provider nearest you.

BENEFITS

All covered benefits explained on the following pages are provided as specified after satisfaction of the deductible and any copay amounts specified in the "What Do I Have To Pay For?" section. All covered benefits, including women's health care benefits, are available without a referral, are subject to the **limitations, exclusions and provisions** of this plan, and services and supplies must be medically necessary. You must receive services from Preferred Plan, participating, or recognized providers (see "Definitions" section), as outlined in the Payment Schedule, to be eligible for the benefits of this plan. 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.

Many services require preauthorization. Preauthorization refers to the process by which the Company determines that a proposed service or supply is medically necessary, as defined in the "Definitions" section. If you or your provider have any questions regarding coverage, please call the phone number listed in the Customer Service Directory.

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 a skilled nursing facility, and for covered services for women's health such as gynecological care and general examinations as medically appropriate and medically appropriate follow-up visits.

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 emergency room copay for each hospital emergency room visit.

Acupuncture: The Professional Services Benefit 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 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 of an ambulatory surgical center will be provided for injury or illness.

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 $14,000 every two calendar years. Medically necessary detoxification will be covered as a medical emergency and expenses incurred will not accrue to the $14,000 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 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.

Colorectal Cancer Screening: The Professional Services and Hospital Services Benefits of this plan will be provided for colorectal cancer screening services, including but not limited to, colonoscopies, sigmoidoscopies, fecal occult tests and barium enemas.

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.

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. Benefits for growth hormones are provided to a maximum of $25,000 per calendar year. 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.
- 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.
- Skilled medical social services.
- 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. Home medical equipment furnished by a Preferred Plan hospital that is not a Preferred Plan home medical equipment company will be provided at the payment level specified for participating providers in the Payment Schedule. 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, a physician's assistant or an 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 the subscriber's female spouse for services incurred while she is covered by this plan. Maternity Benefits are not subject to the preexisting condition waiting periods described in the "When Won't Things Be

Covered?" section. Covered inpatient and postpartum services will be provided when ordered by the attending provider in consultation with the female subscriber or 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 for any complications that may arise.

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 Preferred Plan, participating, or recognized 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 $1,500 per calendar year for all neurodevelopmental therapy services combined. 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. 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 total benefits provided under this plan for occupational injury will be limited to a combined lifetime maximum of $250,000 per subscriber. "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 wages or profit. Benefits for services and supplies to treat occupational injury will only be provided to subscribers who are legally exempt from state industrial insurance, workers' compensation, or similar coverage, and who are not covered under any such insurance coverage.

Preadmission Testing for Surgery: Services of a physician and a 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, a 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 $15,000 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 $1,000 per calendar year. (Not subject to the stoploss provision.)
- All treatment must be prescribed by a Preferred Plan, participating, or recognized 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 to a maximum of $1,000 per occurrence. Services for treatment must begin within 30 days from the date of injury in order for any benefits to be payable for repair of teeth. 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. (Not subject to the stoploss provision.)

Skilled Nursing Facility: Inpatient services and supplies of a skilled nursing facility will be provided for illness, accidental injury, or physical disability, limited to 30 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.

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 physician, psychologist, or smoking cessation provider. No other benefits for smoking cessation will be provided under this plan. (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 also be provided as specified in the Payment Schedule under "Phenylketonuria Formulas" and will not be subject to the waiting periods described in the "When Won't Things Be Covered?" section. 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.

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.

"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 advanced 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 under this plan.

Transplants: Benefits for medically necessary services and supplies related to all transplants will be provided to a combined lifetime maximum of $250,000, 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 - see the Contract).
- Other transplants determined by the Company to be a covered benefit since this plan was issued.

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

Benefits for all transplants 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, only one retransplant will be covered, subject to the benefit limits specified.

Donor Organ Benefits: Donor organ procurement costs will be covered to a maximum of $50,000 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.

Travel Expenses: Travel and lodging expenses for you and your family will be covered when you are required by the Company to travel 75 miles or more from your residence to the facility where the transplant is received for medically necessary services related to an approved transplant. Benefits will be paid at the level specified for Preferred Plan hospitals to a maximum of $2,500 per transplant episode requiring travel and must be approved in advance by the Company.

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 the Contract.
- When donor benefits are available through other group coverage.
- When government funding of any kind is provided.
- Lodging, food or transportation costs, unless otherwise specified under this plan.
- Any service or supplies relating to the transplant if furnished before the recipient has met the transplant waiting period described in the "When Won't Things Be Covered?" section of this brochure.

See the Transplant Waiting Period section for applicable waiting periods.

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

Inpatient: Benefits will be provided for mental disorder treatment when you are confined as an inpatient in 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, to a maximum of 8 days per calendar year. Partial hospital day treatment at a facility will accrue toward the inpatient maximum. Two partial hospital days or two residential treatment days will count as one inpatient day. In order to appropriately administer your benefits, the Company may evaluate diagnostic details, treatment codes, treatment plans and progress notes from the mental health provider. The appropriate level of administrative information about your treatment will be made available to those Company employees who determine that your treatment is a covered service and process claims for payment.

Outpatient: Benefits will also be provided for mental disorder treatment when you are not confined as an inpatient to 12 visits per calendar year for the services of 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. On average, members covered under our Preferred 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.

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.

Mental Health Services and Your Rights:

- Asuris Northwest Health and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan, and to know the limitations on your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, you may contact Asuris Northwest Health at the phone number listed in the Customer Service Directory.
- If you would like to know more about your rights under the law, or if you think anything received from this plan may not conform to the terms of the Contract or rights under the law, you may contact the Office of the Insurance Commissioner at (800) 562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, you may call the State Health Department at (800) 525-0127.

Spinal Manipulations: The Professional Services Benefit of this plan will be provided to a maximum of 12 spinal manipulations per calendar year.

Preventive Care: The benefits of this plan will be provided on an outpatient basis the same as any other illness condition.

- 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 colorectal and prostate cancer screening services are covered separately under the "Benefits" section and are not part of the Preventive Care Benefit. The regular benefits of your plan will apply, and they will not be subject to the deductible.)

All preventive care services will be limited to $500 per person per calendar year.

Preventive Care Benefits are not subject to the deductible.

WHEN WON'T THINGS BE COVERED?

WAITING PERIODS

Transplant Waiting Period: You will not be eligible for any benefits related to a transplant, including stem cell support and high-dose chemotherapy associated with stem cell support until the first day of the thirteenth month of continuous coverage under this and any prior medical plan with the Company, whether or not the condition is preexisting or an emergency. Coverage under the prior plan must have ended when coverage under this plan began. Services and supplies related to a transplant which was performed prior to your effective date of coverage under this or any immediately preceding plan with the Company will not be subject to the transplant waiting period, but will be subject to the preexisting condition waiting period requirements described below.

Preexisting Condition Waiting Period and Credits: A preexisting condition means a condition for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before your enrollment date under this plan. Enrollment date means the earlier of the effective date of coverage under this medical plan or the first day of your group's probationary period, if any, for coverage under this medical plan.

You will not be eligible for benefits for preexisting conditions until you have been covered under this medical plan for three consecutive months from your enrollment date. The waiting period for preexisting conditions does not apply to: coverage for maternity or phenylketonuria (PKU); or to a newborn child, adopted child, or a child placed with a subscriber for adoption who is enrolled within 60 days of birth, adoption or placement, respectively.

You will be allowed a credit against the three-month preexisting condition waiting period of this plan for the amount of similar creditable coverage you had within 90 days of the effective date of coverage under this plan. Alternatively, you will be allowed a credit against the three-month preexisting condition waiting period of this plan for the aggregate amount of prior creditable coverages that you had that were not

interrupted, by more than 63 days at any one time, starting with the 63-day period prior to the effective date of coverage under this plan.

"Creditable coverage" means immediately preceding health coverage, Medicare, Medicaid, military health coverage, FEHBP, the Indian Health Service, a State health benefits risk pool, Peace Corps plan, S-CHIP, self-funded government plans, foreign government plans, United States government plans, or other public health plan.

The following prior coverage types are *not* creditable coverage: limited policies such as accident only, disability income, liability insurance, worker's compensation, automobile medical, credit only, dental only, vision only, long-term care, nursing home care, home health care, community-based care, coverage for a specified disease or illness, Medicare supplement, or other similar limited benefits, if offered separately.

You have the right to demonstrate the existence of prior creditable coverage by providing the Company with one or more certificates of creditable health coverage or other documentation from a prior plan(s) or insurer(s). You can obtain a certificate from a prior plan(s) or insurer(s) by requesting it within 24 months of the cessation of coverage. If necessary, the Company can assist you in obtaining a certificate from a prior plan(s) or insurer(s).

If the Company determines that a preexisting condition waiting period applies to you, the Company will notify you in writing. If you believe the waiting period determination is incorrect, you may appeal the determination by following the appeals and grievance process outlined in the "How Do I File A Claim?" section.

If a claim was paid that was related to a preexisting condition, the payment will not constitute a waiver of this exclusion for that claim or for any subsequent claim if the Company later determines that the condition was preexisting.

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.
- 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; 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 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, or as specified in the "Dental Benefits" section, if any.

- 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.
- 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.
- 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 obtaining or continuing employment, licensure, legal proceedings, insurance, school admission, or sports activities, or which are conducted for purposes of medical research.
- 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.
- 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 and supplies to the extent payable under Medicare Parts A or B when, by law, this plan would not be primary to Medicare had the member properly enrolled in Medicare when first eligible regardless of whether the member actually enrolled.
- 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 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 the group or any of its employees or agents.
- Spinal manipulations, except as specified 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.
- Routine physical examinations and hearing examinations including related x-ray and laboratory, except as specifically provided in the Preventive Care 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 as provided in the Preventive Care Benefit in the "Benefits" section, if any. 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 Contract.) No benefits will be

provided for any drug when the FDA has determined its use to be contra-indicated.

- Routine eye examinations; 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 $20,000.

HOW DO I FILE A CLAIM?

In the Service Area: Be sure to present your Preferred Plan identification card when receiving treatment. Filing of claims for services of Preferred Plan or participating providers, including hospitals, is not necessary. If you receive care from a recognized provider, you may need to submit the claim to the Company yourself. Please see below for information on how to submit claims. 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: Outside the service area, providers and hospitals may direct their bills to you. When the provider or hospital does not bill the Company directly, you must submit them to us. Please see below for information on how to file claims.

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 15 months of the date of service. Claims not submitted within this time limit will not be paid.

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 1-800-434-2277. 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. The Company will have discretionary authority to determine eligibility for benefits or to construe the terms of this plan. 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.

Asuris Northwest Health
Attn: Member Service Specialist
Post Office Box 91130
Seattle, WA 98111

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 30 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 30 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?

COMPANY'S RIGHT TO RECOVER PAYMENTS

If you or a covered dependent is injured by another party who is legally liable, or if you are entitled to be compensated under the terms of any automobile uninsured or underinsured motorist coverage, the benefits of this plan will be available provided you agree to cooperate with the Company in its rights to recover benefit payments and you agree to reimburse the Company for the amount it has paid according to the provisions of the Contract.

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

IMPORTANT NOTICE: This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance Contract, which determines your benefits.

Double Coverage: It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your Contract or contact your state insurance department.

Primary or Secondary? You will be asked to identify all the plans that cover members of your family. The Company needs this information to determine whether the Company is the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary: If you or a family member is covered under another plan in addition to this one, the Company will be primary when:

Your Own Expenses: The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses: The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses: The claim is for the health care expenses of your child who is covered by this plan; and

- You are married and your birthday is earlier in the calendar year than your spouse's or you are living with another

individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule;" or

- You are separated or divorced and you have informed the Company of a court decree that makes you responsible for the child's health care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations: The Company will be primary when any other provisions of state or federal law require the Company to be.

How The Company Pays Claims When The Company is Primary: When the Company is the primary plan, the Company will pay the benefits according to the terms of your Contract, just as if you had no other health care coverage under any other plan.

How The Company Pays Claims When The Company is Secondary: When the Company is knowingly the secondary plan, the Company will make a reasonable estimate of the primary plan payment and base the Company's payment on that amount. After payment information is received from the primary plan, the Company may recover from the primary plan any excess amount paid under the "right of recovery" provision in the plan. The Company may not delay the Company's payments because of lack of information from the primary plan. The Company is required to pay claims within 90 days of receipt.

- If there is a difference between the amounts the plans allow, the Company will base the Company's payment on the higher amount. However, if the primary plan has a contract with the provider, the Company's combined payments will not be more than the amount called for in the Company's contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.
- The Company will determine the Company's payment by subtracting the amount the Company estimates that the primary plan will pay from the amount the Company would have paid if the Company had been primary. The Company must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to

100% of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. The Company is not required to pay an amount in excess of the Company's maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When the plan's deductible is fully credited, the Company will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that the Company does not cover, the Company may pay for those expenses.

- If you are covered by more than one health benefit plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you.

Questions About Coordination of Benefits? Contact Your State Insurance Department.

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 used under a prior plan during that calendar year will be charged against this plan's maximums for that same calendar year. 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 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.
- You will receive credit toward satisfaction of the Transplants Benefit waiting period under this plan only upon direct transfer from another Company medical plan. For more information about waiting period credits, please see the "When Won't Things Be Covered?" section.

TERMINATION OF COVERAGE

Guaranteed Renewability: The continuity of coverage under this plan is guaranteed by the Company for members, except that the Company may terminate this plan for a group or the coverage for an individual for any one of the following reasons:

- Nonpayment of the rate.
- Members who fail to pay any deductible or copay amount owed to the Company and not the provider of health care services.
- Members committing fraudulent acts as to the Company.
- Members who materially breach this plan.
- Violation of published policies of the Company that have been approved by the Washington State Insurance Commissioner, if any.
- There is a change or implementation of federal or state laws that no longer permit the continued offering of this plan.
- There is zero enrollment on the product.
- The Company replaces this product and the replacement product is provided to all members of the group covered under this plan, includes all the services covered under this product, and does not significantly limit access to the kind of services covered under the replaced product. The Company may also allow unrestricted conversion to a fully comparable product.
- The Company withdraws from a service area or from a segment of the service area because the Company has demonstrated to the Washington State Insurance Commissioner that the Company's clinical, financial, or administrative capacity to serve the group or its members would be exceeded.
- The Company discontinues offering this product for groups up to 200 in size. The Company shall provide 90 days' written notification prior to the date of the discontinuance to each group and member enrolled on this product and shall offer to each group the option to enroll in any other product currently being actively marketed by the Company to groups of equivalent size.
- The Company discontinues offering all health coverage for groups up to 200 in size in Washington State and discontinues coverage under all existing group health care plans in the applicable market involved; the Company shall provide 180 days' written notification prior to such discontinuance to the Washington State Insurance Commissioner and all affected groups.

In addition, the group or member may cancel the coverage under this plan upon 30 days' written notice to the Company.

When you are no longer eligible for coverage or leave the group, coverage will cease at the end of the same calendar month. However, you may be eligible for an extension of group benefits as described below. The extension of coverage will end when your group's Contract with the Company terminates (except for the maternity extension).

Certificate of Health Coverage: When your coverage under this plan ends, the Company, in most cases, 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. A certificate will also be issued automatically, as required by law. 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.

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 Contract with the Company terminates.

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

Three-Month Leave of Absence: You and your dependents may continue coverage for a period of not more than three months during a temporary employer-approved leave of absence, provided the rates are paid to the Company. A leave of absence will begin when you are no longer receiving a full salary, but no later than 90 calendar days from the date you are no longer actively at work. Dependent coverage cannot be extended if the employee is not covered.

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 Contract. This extension does not apply for employees whose employment was terminated for misconduct.

Maternity Extension: If a female subscriber or subscriber's female spouse is pregnant when coverage terminates, she will be eligible for the Maternity Benefits of this plan until 14 days following termination of pregnancy, provided she transfers directly to a Company conversion plan and continues coverage until termination of pregnancy. Waiting periods described in the "When Won't Things Be Covered?" section will apply.

Hospital Extension: If you are an inpatient at a facility covered under this plan at the time this plan would be terminated for any reason, your effective date of termination

will be postponed without payment of rate, and this plan will not be terminated for you until the first of the following events occur:

- Expiration of six consecutive months.
- Your remaining benefits available under the plan for your confinement are exhausted (no benefits renew January 1).
- You become covered under another Contract with the Company that provides benefits for your confinement.
- You are enrolled under a contract with another company that would provide benefits for your confinement.
- You are discharged from the facility.

This extension will not apply to the newborn child who is only eligible for coverage for the first 21 days following birth as specified in the Newborn Care Benefit or if you are eligible for a COBRA continuation.

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 three-month 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 Contract. Your payments must continue to be submitted through your group. If your group is subject to COBRA, the COBRA continuation provisions will apply during a labor dispute if you lose your coverage. 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. 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, except as required by law. 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 a self-insured plan, and you or your dependents become covered under the new plan, the conversion options described below will 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. Benefits under the conversion plan will be subject to the 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 plan, 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.

RELEASE OF MEDICAL INFORMATION

As a condition of receiving benefits under this plan, you and your dependents 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 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.

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

- ***Preferred Plan or Participating Providers, Who Have Agreements With The Company or The Parent Company:*** For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between the provider and the Company or Parent Company. These providers agree to seek payment from the Company or Parent 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.
- ***Recognized Providers Inside The Service Area Who Do Not Have Agreements With The Company Or Parent Company:***

    1) For recognized providers who have not signed a current participating or Preferred Plan agreement with the Company or Parent Company, the allowed amount will be no greater than the maximum allowance the Company otherwise would have allowed had the medically necessary covered services been furnished by a participating provider.
    2) For recognized providers who belong to a category of providers who were not offered participating or Preferred Plan agreements, the allowed amount will be equivalent to billed charges.
    3) When you seek services from providers that do not have agreements with the Company or Parent 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.

- ***Out-Of-Area Providers:*** Outside the Service Area, for a given service or supply, the allowed amount will be the amount as determined by the Company or by an independent entity selected by the Company or the amount these providers have agreed to accept as payment in full pursuant to any applicable agreement between the provider and a Regence Group affiliate. 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.

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

Copay: The amount, in addition to the rate, which you are required to pay for certain services and supplies provided under this plan. The copay will be the copay amount 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.

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

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 Company, or is on an investigational protocol, unless approved in writing in advance by the Company.

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.

See the Contract for more detailed information.

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.

Out-of-Area Provider: Outside the service area, a provider 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 in the service area. The out-of-area provider must have the

qualifications and a license or certification equivalent to the qualifications and license or certification required for the comparable provider category inside the service area.

Participating Provider: 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 or for which the Company has arranged for the provision of benefits to its members as a participating provider.

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: 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 or for which the Company has arranged for the provision of benefits to its members as a Preferred Plan provider.

Recognized Provider: Inside the service area, a provider who is acting within the scope of that provider's license, who is not a Preferred Plan or participating provider, or who belongs to a category of providers to whom participating or Preferred Plan agreements are not offered but for whose services this plan provides certain benefits.

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.

Service Area: The State of Washington. Please check our Web site at www.asuris.com for up-to-date information.

Stoploss: The dollar limit of coinsurance amounts that you are responsible to pay for Preferred Plan and out-of-area provider services during a calendar year; after you have reached this limit, the Company will pay most Preferred Plan and out-of-area provider benefits 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: non-Preferred Plan provider services unless otherwise specified; 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.**

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, if you have questions on the second surgical opinion process or the preadmission approval process, or to submit medical claims. For the most up-to-date list of Preferred Plan and participating providers and our service area, please go to our Web site at www.asuris.com.

Toll Free 1-888-344-5587
TTY 1-877-727-4357

ALL CORRESPONDENCE
Asuris Northwest Health
Post Office Box 91130
Seattle, WA 98111

Business Health Trust
Progressive 650
065016-81257
October 1, 2008

P.O. Box 91130
Seattle, Washington 98111

For more information,
call toll-free 1 (888) 344-5587

www.asuris.com

Program Arranged By:
Wells Fargo Insurance Services
520 Pike Street
Seattle, Washington 98101

00324-anh / 3-07