

BOOKLET FOR:



Group Number: 100000007

HSA Healthplan 2,500 Medical Plan



Introduction

Asuris Northwest Health

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This Booklet provides the evidence and a description of the terms and benefits of coverage. The agreement between the Group and Asuris Northwest Health (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

This Booklet describes benefits effective October 1, 2010, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Enrolled Employee and Enrolled Dependents (except that in the eligibility and continuation of coverage sections, the terms "You" and "Your" mean the Enrolled Employee only). The terms "We," "Us" and "Our" refer to Regence BlueShield and the term "Group" means the association through which your employer has made arrangements for its employees to participate under this coverage. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

This coverage is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

Notice of Privacy Practices: Asuris Northwest Health has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION

Customer Service: 1 (877) 508-7361

And visit Our Web site at: www.myAsuris.com

Using Your HSA Healthplan 2,500 Booklet

YOUR PARTNER IN HEALTH CARE

Asuris Northwest Health is pleased that Your Group has chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. Thanks to the purchase of HSA Healthplan 2,500, You have coverage that's comprehensive, affordable and provided by a partner You can trust in times when it matters most.

HSA Healthplan 2,500 provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to Providers and innovative tools. With HSA Healthplan 2,500 health care coverage, You will discover more personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES

HSA Healthplan 2,500 gives You broad access to Providers. HSA Healthplan 2,500 also allows You to control Your out-of-pocket expenses, such as Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under three choices called: "Category 1," "Category 2" and "Category 3."

- **Category 1.** You choose to see a preferred Provider and save the most in Your out-of-pocket expenses. Choosing this category means You will not be billed for balances beyond any Deductible and/or Coinsurance for Covered Services.
- **Category 2.** You choose to see a participating Provider and Your out-of-pocket expenses will generally be higher than if You choose Category 1 because We may negotiate larger discounts with preferred Providers that will result in lower out-of-pocket amounts for You. Choosing this category means You will not be billed for balances beyond any Deductible and/or Coinsurance for Covered Services.
- **Category 3.** You choose to see a Provider that does not have a participating contract with Us and Your out-of-pocket expenses will generally be higher than Category 1. Also, choosing this category means You may be billed for balances beyond any Deductible and/or Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Booklet, We indicate the Provider You may choose and Your payment amount for each Category. Categories 1, 2 and 3 are also in the Definitions Section of this Booklet. You can go to www.myAsuris.com for further Provider network information.

ADDITIONAL MEMBERSHIP ADVANTAGES

When Your Group purchased HSA Healthplan 2,500, You were provided with more than just great coverage. You also acquired Asuris membership, which offers additional valuable services. The advantages of Asuris membership include access to personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to www.myAsuris.com, powered by the Asuris Engine, an interactive environment that can help You navigate Your way through health care decisions. These additional valuable services are a complement to the group health plan, but are not insurance.

- **Go to www.myAsuris.com.** Have Your Member card handy to log on. Use the Web site to view recent claims, get health guidance and support, get access to local events, and use tools for annual planning. It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar.
- **Go to www.regencrx.com or www.myAsuris.com.** Here You can identify Participating Pharmacies, find alternatives to expensive medicines, learn about prescriptions for various Illnesses and even compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

GUIDANCE AND SERVICE ALONG THE WAY

This Booklet was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of HSA Healthplan 2,500 health care coverage and the rewards of Asuris membership throughout this Booklet, some of which are highlighted here. We realize that You may still have some questions about Your HSA Healthplan 2,500 health care coverage, so please contact Us if You do.

- **Learn more and receive answers about Your coverage or any other plan that We offer.** Just call 1 (877) 508-7361 to talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit Our Web site at: www.myAsuris.com.

- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (800) 462-5680.

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Understanding Your Benefits

In this section, You will discover information to help You understand what We mean by Your Maximum Benefits, Deductibles, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

MAXIMUM BENEFITS

Some benefits for Covered Services also may have a specific Maximum Benefit. For those Covered Services, We will provide benefits until the specified Maximum Benefit (which may be a number of days, visits or services, a dollar amount or a specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied toward the Deductible and against any specific Maximum Benefit that is expressed in this Contract as a number of days, visits or services. Refer to the Medical Benefits Sections of this Contract to determine if a Covered Service has a specific Maximum Benefit.

OUT-OF-POCKET MAXIMUM

An important feature of this high deductible health plan is how the single and Family Out-of-Pocket Maximums work. The key is understanding the difference between "single" and "family" coverage. Single Coverage means only one person has coverage under this Contract. An employee who is the only one in his or her Family who has coverage under this Contract, a husband and wife who both work for the Group and have each filled out an application and are Enrolled Employees on separate coverages, and an Enrolled Dependent who is continuing insurance coverage on his or her own are all examples of Single Coverage. Family Coverage, on the other hand, means two or more members of the same Family have coverage under this Contract under a single application.

Members can meet the Out-of-Pocket Maximum by payments of Deductible and Coinsurance for all categories as specifically indicated in the Medical Benefits Section. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach this Contract's Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year.

The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when some or all Family Members' Deductibles) and Coinsurance for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount.

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)

Once You have satisfied any applicable Deductible, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage We pay varies, depending on the kind of service or supply You received and who rendered it.

We do not reimburse Providers for charges above the Allowed Amount. However, a Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible and Coinsurance amount if You choose Category 1 or Category 2. Nonparticipating Providers, however, may bill You for any balances over Our payment level in addition to any applicable Deductible and Coinsurance amount if You choose Category 3. See the Definitions Section for descriptions of Providers.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after the Calendar Year Deductible is satisfied. A Member who is enrolled on Single Coverage satisfies the Single Coverage Deductible by incurring Covered Services during the Calendar Year for which the Allowed Amounts total and meet the Single Coverage Deductible.

The Family Coverage Deductible is satisfied when some or all covered Family Members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Coverage Deductible amount.

We do not pay for services applied toward the Deductible. Refer to the Medical Benefits Section to see if a particular service is not subject to the Deductible. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW

Many provisions of the Contract (for example, Deductibles, Out-of-Pocket Maximum, and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits of this Contract have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Calendar Year. Those exceptions include teaching doses of Self-Administerable Injectable Medication, hospice respite care, and nutritional counseling and are further detailed in the benefits sections of this Booklet.

Medical Benefits

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. There are no referrals required before You can use any of the benefits of this coverage, including women's health care services. For Your ease in finding the information regarding benefits most important to You, We have listed these benefits alphabetically, with the exception of the Professional Services and Preventive Care benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this plan. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Booklet for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

A Health Intervention may be medically indicated yet not be a Covered Service under the Contract or otherwise be Medically Necessary.

If benefits under the Contract change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

ANNUAL MAXIMUM BENEFIT LIMIT

Per Member: \$2,000,000

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Single Coverage: \$3,500

Family Coverage: \$7,000 (two times the Single Coverage maximum amount)

COINSURANCE

Coinsurance is listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES

Single Coverage Deductible: \$2,500

Family Coverage Deductible: \$5,000 (entire Deductible must be met before benefits begin for any Member of the Family.)

You do not need to meet any Deductible before receiving benefits for preventive care, including immunizations.

PROFESSIONAL SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover services and supplies provided by a professional Provider subject to the Deductible and Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services

We cover professional services and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include those to treat a congenital anomaly.

Office Visits

We cover office visits for treatment of Illness or Injury.

Professional Inpatient

We cover professional inpatient visits for Illness or Injury.

Radiology and Laboratory

We cover radiology and laboratory services for treatment of Illness or Injury. This includes, but is not limited to, Medically Necessary mammography and prostate screening services not covered under the Preventive Care benefit.

Diagnostic Procedures

We cover services for diagnostic procedures including cardiovascular testing, colonoscopies, pulmonary function studies, sleep studies and neurology/neuromuscular procedures.

Surgical Services

We cover surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist.

Therapeutic Injections

We cover therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit of the Contract. Teaching doses (by which a Provider educates the Member to self-inject) are covered for this list of Self-Administrable Injectable Medications up to a limit of three doses per medication per Member Lifetime. We consider teaching doses that are applied toward Deductible as benefits provided and apply them against the Maximum Benefit limit on these services.

PREVENTIVE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: We pay 100% of the Allowed Amount, not subject to the Deductible.	Payment: We pay 100% of the Allowed Amount, not subject to the Deductible.	Payment: We pay 100% of the Allowed Amount and You pay balance of billed charges, not subject to the Deductible.

We cover the following preventive care services and supplies provided by a professional Provider or facility. Coverage is provided only for those preventive care services designated by: the United States Preventive Service Task Force (USPSTF) for services with an A or B rating in the current recommendations; by the Health Resources and Services Administration (HRSA); or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) as otherwise specified below:

- We cover routine visits for preventive care, including, but not limited to, well-baby care, screenings for women and routine physical exams.
- We cover routine radiology and laboratory services, including, but not limited to, routine mammography and prostate screening.
- We cover routine procedures, including, but not limited to, routine colonoscopies.
- We cover immunizations for adults and children according to, and as recommended by, the CDC.

Benefits will be covered under this preventive care benefit, not any other provision of the Contract, if services or supplies are in accordance with age limits and frequency guidelines according to, and as recommended by, the USPSTF, CDC or HRSA. For a list of services and supplies covered under this benefit, please visit www.myAsuris.com or contact Customer

Service at 1 (877) 508-7361 NOTE: Covered Services that do not meet this criteria will be covered the same as any other Illness or Injury.

ACUPUNCTURE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 12 visits per Member per Calendar Year. (For acupuncture to treat Chemical Dependency Conditions, refer to the chemical dependency provision in this Medical Benefits Section.)		

We consider visits for these services that are applied toward Deductible as benefits provided and apply them against any Maximum Benefit limit on these services.

AMBULANCE SERVICES

Category: All
Provider: All
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

BLOOD BANK

Category: All
Provider: All
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover the services and supplies of a blood bank, excluding storage costs.

CHEMICAL DEPENDENCY SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover Chemical Dependency Services for treatment of Chemical Dependency Conditions, including the following:

- acupuncture services (when provided for Chemical Dependency Conditions, these acupuncture services do not apply toward the overall acupuncture Maximum Benefit); and
- Prescription Medications that are prescribed and dispensed through a chemical dependency treatment facility (such as methadone).

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Chemical Dependency Services benefit:

Chemical Dependency Conditions means substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

Chemical Dependency Services mean Medically Necessary outpatient services, Residential Care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

Exclusively for the purpose of this Chemical Dependency Benefit, "medically necessary" or "medical necessity" is defined by the American Society of Addiction Medicine patient placement criteria. "Patient placement criteria" means the admission, continued service and discharge criteria set forth in the most recent version of the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

DENTAL HOSPITALIZATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an ambulatory surgical center or Hospital is necessary to safeguard Your health. Benefits are not available for the charges of a dentist or for services received in a dentist's office.

DETOXIFICATION

Category: All
Provider: All
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover Medically Necessary detoxification.

DIABETIC EDUCATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating

Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
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We cover services and supplies for diabetic self-management training and education, including nutritional therapy if provided by Providers with expertise in diabetes.

DIABETES SUPPLIES AND EQUIPMENT

We cover supplies and equipment for the treatment of diabetes. For professional services, diabetic education, Durable Medical Equipment, nutritional counseling, orthotic devices or Prescription Medications see those benefits of this Contract.

DURABLE MEDICAL EQUIPMENT

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Member's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Category: All
Provider: All
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized. See the Hospital benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy, tubal ligation and insertion of IUD or Norplant. See the Prescription Medications benefit for coverage of prescription contraceptives.

GENETIC TESTING

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

HOME HEALTH CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 130 visits per Member per Calendar Year		

We cover home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. We consider visits for these services that are applied toward Deductible as benefits provided and apply them against any Maximum Benefit limit on these services. This Home Health Care Benefit includes coverage for Durable Medical Equipment. For Durable Medical Equipment benefits, see the Durable Medical Equipment Benefit of this Contract.

HOSPICE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, we pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 14 inpatient or outpatient respite care days per Member Lifetime		

We cover hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family

during the final stages of Illness. In order to qualify for hospice care, the patient's Physician must certify that the patient is terminally ill and is eligible for hospice services. Respite care: We cover respite care to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member. We consider respite days that are applied toward Deductible as benefits provided and apply them against any Maximum Benefit limit on these services. Durable Medical Equipment is covered under this benefit when billed by a licensed hospice care program. For a definition of Durable Medical Equipment, see the Durable Medical Equipment Benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SERVICE FACILITY

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Service Facility 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 necessary. See the emergency room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

If benefits under this Contract change while You or an Enrolled Dependent is in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

MATERNITY CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for a female Enrolled Employee or an enrolled female spouse or domestic partner. Also covered is the related routine nursery care of the newborn. There is no limit for the mother and her newborn's length of inpatient stay. Where the mother is attended by a Physician, the attending Physician will determine an appropriate discharge time, in consultation with the mother. Coverage also includes termination of pregnancy for all female Members.

Additionally, We will cover enrolled female children for complications of pregnancy, including:

- fetal distress;
- gestational diabetes; and
- toxemia.

MEDICAL FOODS (PKU)

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

MENTAL HEALTH SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover Mental Health Services for treatment of Mental Health Conditions.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health Services Section:

Mental Health Conditions means Mental Disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under this Contract. Mental Disorders that accompany an excluded diagnosis are covered.

Mental Health Services means Medically Necessary outpatient services, Residential Care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

NEURODEVELOPMENTAL THERAPY

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be

		applied toward the Out-of-Pocket Maximum.
Inpatient: Unlimited Outpatient: 25 visits per Member per Calendar Year		

We cover inpatient and outpatient neurodevelopmental therapy services. To be covered, such services must be to restore and improve function for a Member age six and under with a neurodevelopmental delay. For the purposes of this provision, neurodevelopmental delay means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Member's condition would result without the service. You will not be eligible for both the rehabilitative services benefit and this benefit for the same services for the same condition.

NUTRITIONAL COUNSELING

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 3 visits per Lifetime (diabetic education and counseling is not subject to this limit). We consider visits for these services that are applied toward Deductible as benefits provided and apply them against the Maximum Benefit limit on these services.		

ORTHOTIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. We may elect to provide benefits for a less costly alternative item. We do not cover off-the-shelf shoe inserts and orthopedic shoes.

PRESCRIPTION MEDICATIONS

For Prescription Medications From a Pharmacy

- After Deductible, We pay 80% and You pay 20% of the Covered Prescription Medication Expense for each Generic Medication or Brand-Name Medication. Your 20% payment will be applied toward the Out-of-Pocket Maximum.

For Maintenance Medications From a Mail-Order Supplier

- After Deductible, We pay 80% and You pay 20% of the Covered Prescription Medication Expense for each Generic Medication or Brand-Name Medication. Your 20% payment will be applied toward the Out-of-Pocket Maximum.

Covered Prescription Medications

We cover benefits for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- tobacco use cessation medications when obtained with a Prescription Order, including legend and over-the-counter tobacco cessation medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride and iron) according to, and as recommended by, the United States Preventive Service Task Force, when obtained with a Prescription Order;
- immunizations for adults and children according to, and as recommended by, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Deductible and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, or for immunizations, as specified above. For a list of such medications, please visit www.myAsuris.com or contact Customer Service at 1 (877) 508-7361. NOTE: The applicable Deductible and/or Coinsurance as listed in this Prescription Medications benefit will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. There are more than 1,200 Participating Pharmacies in Our Washington State network from which to choose.

Your Member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Member of Asuris Northwest Health, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find a list of Participating Pharmacies and a Pharmacy locator on Our pharmacy services Web site at www.myAsuris.com, or by contacting Customer Service at 1 (877) 508-7361.

Member's Right To Safe And Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective Pharmacy services, and to guarantee Your right to know what medications are covered and what coverage limitations are under the Contract. If You would like more information about the medication coverage policies under the Contract, or if You have a question or a concern about Pharmacy benefits, please contact Us at 1 (877) 508-7361.

If You would like to know more about Your rights under the law, or if You think anything You have received from Us may not conform to the terms of the Contract, You may contact the Washington State Office of Insurance Commissioner at 1 (800) 562-6900. If You have a concern about the Pharmacists or Pharmacies serving You, please call the State Department of Health at 1 (360) 236-4825.

Preauthorization

Preauthorization may be required so that We can determine that a Prescription Medication is Medically Necessary before it is dispensed. We publish a list of those medications that currently require preauthorization. You can see the list on Our pharmacy services Web site at www.myAsuris.com, or call Customer Service at 1 (877) 508-7361. In addition, We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

Coverage for preauthorized Prescribed Medications begins on the date We preauthorize them. If Your Prescription Medication requires preauthorization and You purchase it before We preauthorize it or without obtaining the preauthorization, the Prescription Medication will not be covered, even if purchased from a Participating Pharmacy.

Limitations

The following limitations apply to this Prescription Medications benefit, except for certain preventive medications as specified in the Covered Prescription Medications section of this provision:

- **Maximum 30-Day or Greater Supply Limit**
 - **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administerable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 30-day supply. The Coinsurance for Self-Administerable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from, and the claim was submitted electronically by, a Pharmacy.
 - **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Maintenance Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities.
 - **Pharmacy and 90-Day Supply.** The largest allowable quantity of Prescription Medication that You may purchase from a Pharmacy and for which a single claim may be submitted is a 90-day supply. A Provider may choose to prescribe, or You may choose to purchase, some medications in smaller quantities.

- **Maximum Quantity Limit**

For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Member card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by checking Our pharmacy services Web site at www.myAsuris.com, or contacting Customer Service at 1 (877) 508-7361. We do not cover any amount over the established maximum quantity, except if We determine the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

- **Refills**

We will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible. If You feel You need a refill sooner than allowed, a refill exception will be considered at Our discretion on a case-by-case basis. You may request an exception by calling Customer Service at 1 (877) 508-7361.

- **Prescription Medications Dispensed by Excluded Pharmacies**

A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription Medications from a non-excluded Pharmacy. We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the OIG list.

Exclusions

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medications benefit:

Biological Sera, Blood or Blood Plasma

Certain Contraceptives: Prescription contraceptives that cannot be self-administered, including Norplant, surgically inserted contraceptive devices, IUDs and Depo-Provera (coverage for these contraceptives may otherwise be provided under the Medical Benefits Section of the Contract).

Cosmetic Purposes: Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.

Devices or Appliances: Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section of the Contract).

Foreign Prescription Medications: Foreign Prescription Medications, except those associated with an Emergency Medical Condition while You are traveling outside the United States, or those You purchase while residing outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States, except as may be provided under the

Investigational definition in the Definitions Section of the Contract found at the back of this Booklet.

Growth Hormones: Growth hormones, unless We preauthorize them.

Inhibition and/or Suppression of Sleepiness: Prescription Medications used to inhibit and/or suppress drowsiness, sleepiness, tiredness or exhaustion, unless We preauthorize them.

Insulin Pumps and Pump Administration Supplies: Coverage for insulin pumps and supplies is provided under the Medical Benefits Section of the Contract.

Medications We Don't Consider Self-Adminstrable: Coverage for these medications may otherwise be provided under the Medical Benefits Section of the Contract.

Nonprescription Medications: Medications that by law do not require a Prescription Order and which are not included in Our definition of Prescription Medications, shown below, unless included on Our Formulary.

Off-Label Use Prescription Medications: Prescription Medications that have not yet received FDA approval for the purpose and in the manner they are being prescribed, except as may be provided under the Investigational definition in the Definitions Section of the Contract found at the back of this Booklet.

Onychomycosis: Prescription Medications for the treatment of Onychomycosis (nail fungus), unless We preauthorize them.

Prescription Medications Dispensed in a Facility: Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications Dispensed in Connection with Participation in a Clinical Trial

Prescription Medications for Treatment of Infertility

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not within a Provider's License: Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with No FDA Proven Therapeutic Indication

Prescription Medications without Examination: Prescriptions made by a Provider without recent and relevant in-person examination of the patient (except as specifically allowed under the telemedicine benefit in the Medical Benefits Section of the Contract), whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medications benefit:

Brand-Name Medication means a Prescription Medication that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a Brand-Name Medication based on manufacturer and price.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA.

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Mail-Order Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Mail-Order Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.

Formulary means Our list of selected Prescription Medications. We established Our Formulary and We review and update it routinely. It is available on Our pharmacy services Web site at www.myAsuris.com, or by calling Customer Service at 1 (877) 508-7361. Medications are reviewed and selected for inclusion in Our Formulary by an outside committee of providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication, is marketed as a therapeutically equivalent and interchangeable product and is listed in widely accepted references (or specified by Us) as a Generic Medication. For the purposes of this definition, "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards and is absorbed into the bloodstream at the same rate and same total amount as the Brand-Name Medication. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, We will decide.

Mail-Order Supplier means a mail-order Pharmacy with which We have contracted for mail-order services.

Maintenance Medication means a Prescription Medication that We determine is intended to treat a chronic illness that requires long-term medication therapy.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works and its possible adverse effects and perform other duties as described in his or her state's Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy means either a Pharmacy with which We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. A Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an illness or injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Caution - federal law prohibits dispensing without prescription," or that We specifically designate as such.

Prescription Order means a written prescription or oral request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Adminstrable Prescription Medications (also Self-Adminstrable Medications, or Self-Adminstrable Injectable Medication) means, a Prescription Medication, determined by Us, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what We consider Self-Adminstrable Medications, We refer to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that We consider a relevant and reliable indication of safety and acceptability. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-adminstrable.

PROSTHETIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital inpatient care or Hospital outpatient and Ambulatory Service Facility care) in this Medical Benefits Section. We will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

REHABILITATION SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: 30 days per Member per Calendar Year Outpatient limit: 25 visits per Member per Calendar Year		

We cover inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. You will not be eligible for both the neurodevelopmental therapy benefit and this benefit for the same services for the same condition.

SKILLED NURSING FACILITY (SNF) CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 60 inpatient days per Member per Calendar Year		

We cover the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. We consider days for these services that are applied toward Deductible as benefits provided and apply them against any Maximum Benefit limit on these services.

SPINAL MANIPULATIONS

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 10 spinal manipulations per Member per Calendar Year		

We cover spinal manipulations performed by any Provider. We consider manipulations that are applied toward Deductible as benefits provided and apply them against any Maximum Benefit limit on these services. Manipulations of extremities are covered under the neurodevelopmental therapy and rehabilitation services benefits in this Medical Benefits Section.

TELEMEDICINE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover telemedicine (audio and video communication) services between a distant-site Physician, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.

TRANSPLANTS

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and 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). This list of transplants is subject to change. Members can contact Us for a current list of covered transplants.

Donor Organ Benefits

We cover donor organ procurement costs 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 procurement costs that We determine.

Transplant Waiting Period

You will not be eligible for any benefits related to a transplant until the first day of the sixth month of continuous coverage under this or any previous medical plan with Us, whether or not the condition is preexisting.

We will reduce the duration of the transplant waiting period by the amount of Your combined periods of creditable coverage if You have been covered by creditable coverage. For crediting to apply for more than one creditable coverage, there must have been no break in creditable coverage greater than sixty-three days immediately preceding Your enrollment date of coverage under the Contract or between any two successive creditable coverages for which You seek credit. For the purposes of the transplant waiting period, creditable coverage also includes one immediately previous and otherwise creditable coverage that terminated in the period beginning ninety days and ending sixty-four days before the date of application for coverage under the Contract. Creditable coverage may still be in force at the time credit for it is sought on this coverage.

Employee Assistance Program

An Employee Assistance Program ("EAP") is an important component of a Group-sponsored preventive care package and Your Group has chosen to provide this benefit to You. The EAP provides short-term, confidential counseling at no out-of-pocket expense to You. The EAP is available to You and Your immediate family, including family members living in Your home (who may or may not be enrolled in this coverage). Please contact Us or Your Group for more information regarding EAP coverage and for contact information.

SERVICES PROVIDED

The following services are provided as part of the EAP package:

24-Hour Crisis Counseling

The EAP hotline number is answered by professional counselors 24 hours a day, 7 days per week.

Short-Term Counseling

If the problem can be resolved within the scope of the EAP, the counselor provides this service to the individual(s). Up to four counseling sessions will be allowed per incident. An "incident" means a discrete event or events occurring in the client's life. We will allow each family member affected by an incident a total of four counseling sessions. If two or more members of the same family are seen together in a conjoint session, the session is counted as one visit for each attending family member. Eligible family members are those individuals living in the same residence with You.

Referral

If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor will refer the individual to community resources that are best suited to address the issue.

Follow-up

When necessary and appropriate, the counselor follows up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if the EAP service can be of further assistance.

General Exclusions

The following are the general exclusions from coverage under the Contract. Other exclusions may apply and, if so, will be described elsewhere in this Booklet.

EXCLUSION PERIOD FOR PREEXISTING CONDITIONS

This coverage has an exclusion period for Preexisting Conditions. This means that We do not pay for expenses You incur for treatment of Preexisting Conditions during the time period described in the following paragraphs. Our payment of a claim related to a Preexisting Condition does not mean that this limitation is waived for that claim or for any subsequent claim if We later determine the condition was preexisting.

Preexisting Condition

By Preexisting Condition, We mean a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 3-month period before the enrollment date. If You enrolled during Your initial period of eligibility, enrollment date means Your Effective Date of coverage or, if earlier, the first day of any waiting period for coverage applied to You. If You enrolled during a special enrollment, the enrollment date is the Effective Date of coverage. Pregnancy and phenylketonuria (PKU) are not considered Preexisting Conditions. Genetic information will not be considered a Preexisting Condition in the absence of a diagnosis related to such information. In addition, exclusion periods for Preexisting Conditions are not imposed on a Member who is enrolled prior to reaching 19 years of age.

Exclusion Period Time Limit

The exclusion period will end three months following Your enrollment date.

Creditable Coverage

We will reduce the duration of the Preexisting Condition exclusion period by the amount of Your combined periods of creditable coverage if You have been covered by creditable coverage. For crediting to apply for more than one creditable coverage, there must have been no break in creditable coverage greater than 63 days immediately preceding Your enrollment date of coverage under the Contract or between any two successive creditable coverages for which You seek credit. Creditable coverage may still be in force at the time credit for it is sought on this coverage.

You will be allowed a credit against the Preexisting Condition exclusion period under this Contract for the combined amount of prior creditable coverages that You have had. If You have had more than one creditable coverage in effect at the same time, credit is given only for one (that is, a day on which You have creditable coverage in force under two coverages is not counted as two days of creditable coverage). In calculating Your creditable coverage credit, if You have had a break in coverage (that is, a period between the termination date of one creditable coverage and the enrollment date on next creditable coverage) of 63 days or more, no credit will be given for any creditable coverages prior to that break in coverage. Washington state law offers a separate opportunity for credit. If You had previous coverage similar to this Contract's coverage and that previous coverage terminated 63 days or more, but not more than 90 days, before Your date of application for this coverage, You will be allowed a credit against this Contract's Preexisting Condition exclusion period for that one **and only that one** previous coverage, regardless of whether it is creditable coverage under the definition below.

Creditable coverage means any of the following: group coverage (including self-funded plans); individual insurance coverage; S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high-risk pool coverage; Federal Employee Health Benefit Plan coverage; and public health plans (including foreign government and US government plans).

Creditable coverage is determined separately for each Member.

The following periods do not count in the calculation of the length of a break in coverage:

- days in a waiting period for eligibility for coverage under the Contract; and
- for an individual who elects COBRA continuation coverage during the second election period offered under the Trade Act of 2002, days between the loss of coverage and the first day of that second election period.

You have the right to demonstrate the existence of creditable coverage by providing Us with one or more certificates of creditable coverage from a prior group or individual plan or with other documentation. You may obtain a certificate of creditable coverage from a prior group health plan or insurer by requesting it within 24 months of coverage termination. We can help You obtain a certificate from a prior plan or insurer or suggest other documents that will serve as alternatives to a certificate of creditable coverage as provided by federal law.

SPECIFIC EXCLUSIONS

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury; or 2) a preventive service as specified under the Preventive Care benefit in the Medical Benefits Section.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Member's 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.

Cosmetic/Reconstructive Services and Supplies

Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a congenital anomaly;
- to restore a physical bodily function lost as a result of Injury or Illness; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice of this Contract.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness

Counseling in the absence of Illness (for example, educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program ("EAP") services, except as specifically provided under the EAP Section, if applicable; wilderness programs; premarital or marital counseling; family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits under this Contract).

Custodial Care

Non-skilled care and helping with activities of daily living.

Dental Services

Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

Fees, Taxes, Interest

Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Foot Care (Routine)

Routine foot care, including, but not limited to: treatment of corns and calluses and trimming of nails, except when indicated for diabetic patients.

Government Programs

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 contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except as required by law for emergency services).

Growth Hormone Therapy

Growth hormone therapy, except as provided under the Prescription Medications benefit of the Contract.

Hearing Care

Routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

Infertility

Treatment of infertility, except to the extent Covered Services are required to diagnose such condition including, but not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception) and fertility drugs and medications.

Investigational Services

Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section of this Contract.

Mental Health Treatment For Certain Conditions

We will not cover Mental Health Treatment for diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) for all ages. Additionally, We will not cover any "V code" diagnoses except the following when Medically Necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger. By "V code," We mean codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the Diagnostic DSM-IV TR that describes Relational Problems, Problems Related To Abuse Or Neglect or other issues that

may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.

Motor Vehicle Coverage and Other Insurance Liability

Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, We will provide benefits according to the Contract.

Non-Direct Patient Care

Services that are not direct patient care, including:

- appointments scheduled and not kept ("missed appointments");
- charges for preparing medical reports;
- itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as specifically provided under the telemedicine benefit.

Obesity or Weight Reduction/Control

Medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions (except as provided under the nutritional counseling benefit in the Medical Benefits Section).

Orthognathic Surgery

Services and supplies for orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to a temporomandibular joint disorder, Injury, sleep apnea or congenital anomaly.

Over the Counter Contraceptives

Over-the-counter contraceptive supplies and oral contraceptives, except where included under the Prescription Medication benefits of the Contract.

Personal Comfort Items

Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.

Physical Exercise Programs and Equipment

Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Member's Provider.

Private-Duty Nursing

Private-duty nursing, including ongoing shift care in the home.

Reversals of Sterilizations

Services and supplies related to reversals of sterilization.

Riot, Rebellion and Illegal Acts

Services and supplies for treatment of an Illness, Injury or condition caused by a Member's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Member arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs

Self-help, non-medical self-care, training programs, including:

- diet and weight monitoring services;
- childbirth-related classes including infant care and breast feeding classes; and
- instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member.

This exclusion does not apply to services for training or educating a Member when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service in the Medical Benefits Section (for example, nutritional counseling, diabetic education and teaching doses for Self-Administerable Injectable Medications).

Services and Supplies Provided by a Member of Your Family

Services and supplies provided to You by a Member of Your immediate family. For purposes of this provision, "immediate family" means parents, spouse, children, siblings, half-siblings, in-laws or any relative by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary

Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided under the Contract.

Sexual Dysfunction

Services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners when Mental Health Services are covered benefits under this Contract.

Sexual Reassignment Treatment and Surgery

Treatment, surgery or counseling services for sexual reassignment.

Third Party Liability

Services and supplies for treatment of Illness or Injury for which a third party is or may be responsible.

Tobacco Addiction Treatment

Treatment of tobacco addiction, unless specifically provided under the Contract.

Travel and Transportation Expenses

Travel and transportation expenses other than covered ambulance services provided in the Contract.

Vision Care

Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions

Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. We may require the Member to file a claim for workers' compensation benefits before providing any benefits under the Contract. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if an Enrolled Employee is exempt from state or federal workers' compensation law.

Contract and Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us.

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious illness or injury that have the potential for continuing major or complex resource use. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

ALTERNATIVE BENEFITS

Alternative benefits means benefits for services or supplies that are not otherwise covered under the Contract, but for which We may approve coverage after case management evaluation and analysis. We may cover alternative benefits through case management if We determine, in Our sole discretion, that alternative benefits are Medically Necessary and will result in overall reduced covered costs and improved quality of care. Before coverage of alternative benefits and before the processing of claims for alternative benefits, We, You or Your legal representative and, if required by Us (in Our sole discretion), Your Physician or other Provider must agree in writing to the specific terms and conditions for payment. Alternative benefits are approved on a case-specific basis only. The fact that We may cover alternative benefits for You does not set any precedent for coverage of continued or additional alternative benefits for You, or anyone else covered under the Contract.

MEMBER CARD

When You, the Enrolled Employee, enroll with Asuris Northwest Health, You will receive a Member card. It will include important information such as Your identification number, Your Group number and Your name.

It is important to keep Your Member card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling Our Customer Service department at 1 (877) 508-7361 or by visiting Our Web site at www.myAsuris.com. If coverage under the Contract terminates, Your Member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

We have the sole right to decide whether to pay You, the Provider or You and the Provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

You will be responsible for the total billed charges for benefits in excess of any Maximum Benefits, and for charges for any other service or supply not covered under the Contract, regardless of the Provider rendering such service or supply.

Calendar Year and Contract Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. This Contract is renewed, with or without changes, each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. A Contract Year may or may not be the same as a Calendar Year. When Your Contract renews on other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Contract renews will be carried over into the next Contract Year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year,

You will need to meet the new requirement minus any amount You already satisfied under the previous Contract during that same Calendar Year.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. We will deny a claim that is not filed in a timely manner unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider

Nothing contained in the Contract is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

Category 1 and Category 2 Claims

You must present Your Member card when obtaining Covered Services from a preferred or participating Provider. You must also furnish any additional information requested. The Provider will furnish Us with the forms and information We need to process Your claim.

Category 1 and Category 2 Reimbursement

We will pay a preferred or participating Provider directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Category 3 Claims

In order for Us to pay for Covered Services, You or the nonparticipating Provider must first send Us a claim. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis; and
- the patient's name and the group and identification numbers.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send Us the claim.

Category 3 Reimbursement

In most cases, We will pay You directly for Covered Services provided by a nonparticipating Provider.

Nonparticipating Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the nonparticipating Provider and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For nonparticipating Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

Reimbursement Examples By Category

Here is an example of how Your selection of Category 1, 2 or 3 affects Our payment to Providers and Your cost sharing amount. For purposes of this example, let's assume We pay 80 percent of the Allowed Amount for Category 1 and 60 percent of the Allowed Amount for Categories 2 and 3. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, We pay 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Now, let's assume that the Provider's charge for a service is \$5,000 and the Allowed Amount for that charge is \$3,800 for Category 1 and \$4,000 for Categories 2 and 3. Finally, We will assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- Category 1: We would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
 - Amount preferred Provider must "write-off" (that is, cannot charge You for): \$1,200
 - Amount We pay (80% of the \$3,800 Allowed Amount): \$3,040
 - **Amount You pay** (20% of the \$3,800 Allowed Amount): **\$760**
 - Total: \$5,000
- Category 2: We would pay 60 percent of the Allowed Amount and You would pay 40 percent of the Allowed Amount, as follows:
 - Amount participating Provider must "write-off" (that is, cannot charge You for): \$1,000
 - Amount We pay (60% of the \$4,000 Allowed Amount): \$2,400
 - **Amount You pay** (40% of the \$4,000 Allowed Amount): **\$1,600**
 - Total: \$5,000
- Category 3: We would pay 60 percent of the Allowed Amount. Because the nonparticipating Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus, the difference between the nonparticipating Provider's billed charges and the Allowed Amount, as follows:
 - Difference between billed charges and Allowed Amount: \$1,000
 - Amount We pay (60% of the \$4,000 Allowed Amount): \$2,400
 - **Amount You pay** (40% of the \$4,000 Allowed Amount and the \$1,000 difference between the billed charges and the Allowed Amount): **\$2,600**
 - Total: \$5,000

The actual benefits of the Contract may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

Ambulance Claims

When You or Your Provider forwards a claim for ambulance services to Us, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's group and identification numbers.

Prescription Medication Claims Submitted Electronically

You must present Your Member card at a Participating or a Nonparticipating Pharmacy for the claim to be submitted electronically. You must pay any required Deductible and/or Coinsurance at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, We will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well

as any Deductible and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Prescription Medication Claims Not Submitted Electronically

When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to Us. We will reimburse You based on the Covered Prescription Medication Expense, less the applicable Deductible and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. We will send payment directly to You.

It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Deductible and/or Coinsurance.

Prescription Medication Mail-Order

You can also use mail-order services to purchase covered Maintenance Medications. Mail-order coverage applies only when Prescription Medications are purchased from a Mail-Order Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Mail-Order Suppliers.

To buy Maintenance Medication through the mail, simply send all of the following items to a Mail-Order Supplier at the address shown on the prescription mail-order form available on Our pharmacy services Web site at www.myAsuris.com, or from Your Group (which also includes refill instructions):

- a completed prescription mail-order form;
- any Deductible and/or Coinsurance; and
- the original Prescription Order.

Claims Determinations

Within 30 days of Our receipt of a claim, We will notify You of the action We have taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When We cannot take action on the claim due to circumstances beyond Our control, We will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when We expect to act on the claim.
- When We cannot take action on the claim due to lack of information, We will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

We must allow You at least 45 days to provide Us with the additional information if We are seeking it from You. If We do not receive the requested information to process the claim within the time We have allowed, We will deny the claim.

NONASSIGNMENT

Only You are entitled to benefits under the Contract. 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 or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on Us. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

CLAIMS RECOVERY

If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right, at Our discretion, to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Enrolled Employee or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

We regularly work to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to Your Group's experience or the experience of the pool under which You or Your Group is rated. Crediting reduces claims expense and helps reduce future premium rate increases.

This claims recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the other-party liability provision in the Contract and Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by Us. This information will be used in accordance with Our Notice of Privacy Practices. You can request a copy simply by calling Our Customer Service department at 1 (877) 508-7361 or by visiting Our Web site at www.myAsuris.com.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, Hospital, long-term care or other medical facility; or
- a Physician, dentist, Pharmacist or other physical or behavioral health care practitioner.

Health information requested or disclosed by Us may include, but is not limited to:

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

We are required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling Our Customer Service department or visiting Our Web site www.myAsuris.com.

You have the right to request, inspect and amend any records that We have that contain Your personal health information. Please contact Our Customer Service department to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for Us to receive information related to these health conditions.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Since We do not provide any health care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither Our employees nor agents. We are responsible for the quality of health care You receive only as provided by law.

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the Contract by reason of epidemic, disaster or other cause or condition beyond Our control.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

This section explains how We treat various matters having to do with administering Your benefits and/or claims, including situations that may arise in which Your health care expenses are the responsibility of a source other than Us.

Third-Party Liability

This provision applies when You incur health care expenses in connection with an Illness or Injury for which one or more third parties may be responsible. In that situation, benefits for otherwise Covered Services are excluded under this Contract to the extent You receive a recovery from or on behalf of the responsible third party in excess of full compensation for the loss. We refer to the legally liable party as the "third party" in this provision. If You do not pursue a recovery of the benefits We have advanced, We may choose, in Our discretion, to pursue recovery on Your behalf (this is called subrogation).

Here are some rules which apply in these third-party liability situations:

- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible third party, We will advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the third party in trust for Us to the extent it exceeds full compensation to You for the loss, up to the amount of benefits We paid in connection with the Illness or Injury.
- You and/or Your agent or attorney must agree to keep segregated in its own account the amount of the benefits We have paid for the condition from any recovery or payment of any kind for Your benefit or on Your behalf that is in any manner related to the Illness or Injury giving rise to Our right to reimbursement, until Our right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Injury or Illness through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which We have provided benefits, to the extent it exceeds full compensation to You for the loss. This is true regardless of whether:
 - the third party or the third party's insurer admits liability;
 - the health care expenses are itemized or expressly excluded in the third-party recovery;
 - or

- the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Contract. The amount to be held in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.
- Any benefits We advance are solely to assist You. By advancing such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorists insurance. When We use the term motor vehicle insurance below, it includes medical expense coverage, personal injury protection coverage, uninsured motorists coverage, underinsured motorists coverage or any coverage similar to any of these coverages. Benefits for health care expenses are excluded under this Contract if You receive payments from uninsured motorists coverage or underinsured motorists coverage for such expenses to the extent those payments exceed the amount necessary to fully compensate You, along with all other payments You receive to compensate You for Your Injuries, losses or damages, for those Injuries, losses or damages.

Here are some rules which apply with regard to motor vehicle insurance coverage:

- If a claim for health care expenses arising out of a motor vehicle accident is filed with Us and motor vehicle insurance has not yet paid, We may advance benefits for Covered Services as long as You agree in writing:
 - to give Us information about any motor vehicle insurance coverage which may be available to You; and
 - to otherwise secure Our rights and Your rights.
- If We have paid benefits before motor vehicle insurance has paid, We are entitled to have the amount of the benefits We have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of You held in trust for Us. The amount of benefits We are entitled to will never exceed the amount You receive from all insurance sources that fully compensates You for Your loss and We will only seek to recover amounts You have received from other insurance sources to the extent those amounts exceed full compensation to You for Your Injuries, losses or damages.
- You may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the Third-Party Liability provision apply. However, We will not seek double reimbursement.

Workers' Compensation

This provision applies if You have filed or are entitled to file a claim for workers' compensation. Benefits for treatment of an Illness or Injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Contract. The only exception would be if the Enrolled Employee is exempt from state or federal workers' compensation law.

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

- You must notify Us in writing within five days of any of the following:
 - filing a claim;
 - having the claim accepted or rejected;
 - appealing any decision;
 - settling or otherwise resolving the claim; or
 - any other change in status of Your claim.

- If the entity providing workers' compensation coverage denies Your claims and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Third-Party Liability provision.

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining recovery. If this plan is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this plan is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us.

COORDINATION OF BENEFITS

The coordination of benefits (COB) provision applies when You have health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Coordination of Benefits Under an HSA Plan

This high deductible health plan was designed for use in conjunction with a health savings account (HSA), but can be maintained without an HSA. Laws strictly limit the types of other coverages that an HSA participant may carry in addition to his or her high deductible health plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. We will coordinate benefits according to this coordination of benefits provision, regardless of whether other coverage is permissible under HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

Definitions

For the purpose of this Section, the following definitions shall apply:

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

- Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under the above bullet points is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means, in a COB provision the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a "Primary Plan" or "Secondary Plan" when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and 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 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100 percent of the highest Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for You. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its Maximum Benefit plus any accrued savings.

Allowable Expense is a health care expense, including deductibles, Coinsurance and copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- If You are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If You are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

Closed Panel Plan is a Plan that provides health care benefits to You in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When You are covered by two or more Plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan. A Plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington

Administrative Code is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The Plan that covers You other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers You as a dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a dependent, and primary to the Plan covering You as other than a dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

- For a child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
- For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
 - If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
 - If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial Parent, first;

The Plan covering the spouse of the Custodial Parent, second;

The Plan covering the noncustodial parent, third; and then

The Plan covering the spouse of the noncustodial parent, last.

- For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a dependent of an active employee and You are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

COBRA or State Continuation Coverage. If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered You as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of this Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan 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 100 percent of the total Allowable Expense for that claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering You. We need not tell, or get the consent of, any person to do this. You, to claim benefits under This Plan, must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

If payments that should have been made under This Plan are made by another Plan, We have the right, at Our discretion, to remit to the other Plan the amount We determine appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, We are fully discharged from liability under This Plan.

Right of Recovery

We have the right to recover excess payment whenever We have paid Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

If the Group or you have questions about this coordination of benefits provision, please contact the Washington State Insurance Department.

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under the Contract and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Asuris Northwest Health P.O. Box 1271, MS C7B, Portland, OR 97207-1271. Verbal requests can be made by calling Us at 1 (877) 508-7361.

Each level of Appeal, including expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the first level, within 180 days of Your receipt of Our original adverse decision that You are appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement and information describing the entire Appeal process and Your rights.

If Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular Appeal process, he or she may specifically request an expedited Appeal. Please see Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. A written notice of the decision will be sent within 14 days of receiving the Appeal unless We notify You that an extension is necessary to complete the Appeal; however, with notification of an extension, the decision will be sent within 30 days of the request for Appeal. An extension cannot delay the decision beyond 30 days without Your informed written consent. For Appeals involving a Post-Service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt of the Appeal and within five working days of the decision being made. For Appeals involving a Pre-Service preauthorization of a procedure (including a Pre-Service Investigational procedure), We will send a written notice of the decision within 14 days of receipt of the Appeal.

Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the first-level decision. You or Your Representative, on Your behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference or other technology and/or to provide written materials. A written notice of the decision will be sent within 14 days of receiving the Appeal unless We notify You that an extension is necessary to complete the Appeal; however, with notification of an extension, the decision will be sent within 30 days of the request for Appeal. An extension cannot delay the decision beyond 30 days without Your informed written consent. For Appeals involving a Post-Service Investigational issue, a written notice of the decision will be sent within 20 working days of receipt of the Appeal and within five working days of the decision being made. For all other Post-Service Appeals, a written notice of the decision will be sent within 14 days of receipt of the 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. For Appeals involving a Pre-Service preauthorization of a procedure (including a Pre-Service Investigational procedure), We will send a written notice of the decision within 14 days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if We have failed to provide You with a first-level or panel-level Appeal decision within the timeframes given.

We coordinate voluntary external Appeals, but the decision is made by an Independent Review Organization (IRO) at no cost to You. We will provide the IRO with the Appeal documentation. A written notice of the IRO's decision will be sent to You within 30 days of receipt of Your request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with Us. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

EXPEDITED APPEALS

An expedited Appeal is available if one of the following applies:

- the application of regular Appeal timeframes on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function, or
- according to a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Panel-Level (First-Level) Expedited Appeal

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the initial denial determination. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited Appeals timeframe) to participate via telephone and/or provide written materials. A verbal and written notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal.

Voluntary Expedited Appeal - IRO

If You disagree with the decision made in the panel-level Appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service), You may request a voluntary expedited Appeal to an IRO. The criteria for a voluntary expedited Appeal to an IRO are the same as described above for non-urgent IRO review.

We coordinate voluntary expedited Appeals, but the decision is made by an IRO at no cost to You. In order to have the Appeal decided by an IRO, You must sign a waiver granting the IRO access to medical records. We will provide the IRO with the Appeal documentation. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of Your request. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

The voluntary expedited Appeal by an IRO is optional and You should know that other forums may be used as the final level of expedited Appeal to resolve a dispute You have with Us, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If You have any questions about the Appeal Process outlined here, You may contact Our Customer Service department at 1 (877) 508-7361 or You can write to Our Customer Service department at the following address: Asuris Northwest Health, P.O. Box 30271, Salt Lake City, UT 84130-0271.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Representative, to change a previous decision made by Us concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Member and Us; and
- other matters as specifically required by state law or regulation.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary expedited external Appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

Medical Director means for purposes of the Appeal process only, a Physician employed by, or consulted by, Us. The Medical Director will reserve the right, if not appropriately qualified to review a particular procedure, to consult with an outside Practitioner with specialty in the medical condition/procedure involved in the review.

Post-Service means any claim for benefits under the Contract that is not considered Pre-Service.

Pre-Service means any claim for benefits under the Contract which We must approve in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the purpose of the Appeal. The Representative may be Your personal Representative or a treating provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purposes of the Appeal. No authorization is required from the parent(s) or legal guardian of a Member who is an unmarried and dependent child and is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You, Your personal Representative or treating provider only.

Who Is Eligible, How to Enroll and When Coverage Begins

This section contains the terms of eligibility under the Contract for an employee and his or her dependents. It explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual enrollment period. It also describes when coverage under the Contract begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Group and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

Except as described under the special enrollment provision, if You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees

You become eligible to enroll in coverage on the date You have worked for a Member Employer long enough to satisfy any required probationary period.

Dependents

Your Enrolled Dependents are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when We have enrolled them in coverage under the Contract. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your registered domestic partner or domestic partner for whom You have submitted an accurate and complete affidavit of qualifying domestic partnership ("domestic partner").
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
 - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
 - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
 - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
 - he or she is an enrolled child immediately before his or her 26th birthday; or
 - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site at www.myAsuris.com, or by calling Our Customer Service department at 1 (877) 508-7361. We may request updates on the child's disability or handicap at reasonable times as We consider necessary (but this will not be more often than annually following the dependent's 28th birthday).

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a non-registered domestic partner, an affidavit of qualifying domestic partnership form) to Us. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption if payment of additional premium is required to provide coverage for the child. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

NOTE: The regular benefits of the Contract will be provided for a newborn child for up to 21 days following birth when delivery of the child is covered under the Contract. Such benefits will not be subject to enrollment requirements for a newborn as specified here, or the payment of a separate premium for coverage of the child. Coverage, however, is subject to all provisions, limitations and exclusions of the Contract. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn. When delivery of a child is not covered under the Contract, benefits will be provided for routine care for that newborn child while hospitalized for up to the first 72 hours following birth, not subject to the enrollment requirements for a newborn specified here.

NOTE: Due to the nature of this high deductible health plan, adding dependents after January 1 of any year may change Your coverage from Single Coverage to Family Coverage, and may change the amount of Deductible and Out-of-Pocket Maximum that applies to Your coverage.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual enrollment period.

Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage, though it may include Your decision to take another action (e.g., terminating employment) that results in a loss of eligibility.

If You declined coverage when first eligible and subsequently have one of the following qualifying events, You, Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 30 days from the date of the qualifying event (except that, where the qualifying event is exhaustion of Lifetime maximum on total benefits, You have 30 days from the date the first claim is denied on the basis of Lifetime maximum exhaustion to enroll; or where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
 - an employer's contributions to that other plan are terminated;
 - exhaustion of federal COBRA or any state continuation;
 - loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours; or
 - exhaustion of Lifetime maximum on total benefits.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

If You declined coverage when first eligible and subsequently have one of the following qualifying events, You, Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 30 days from the date of the qualifying event, except that, where the qualifying event is: You and/or Your dependent(s) becoming eligible for premium assistance under Medicaid or Children's Health Insurance Program (CHIP), You have 60 days to enroll, measured from the date of the qualifying event:

- You marry or begin a domestic partnership.
- You acquire a new child by birth, adoption, or placement for adoption.
- You and/or Your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).
- The Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective for an eligible dependent to have coverage under the Contract. In this case, the dependent is eligible for coverage under the Contract.

For all qualifying events, if You enroll as required, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where the qualifying event is a child's birth, adoption, or placement for adoption, or You marry or begin a domestic partnership, coverage is effective from the date of the qualifying event.

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the period of time before Your Member Employer's Renewal Date and is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form (and, in the case of a non-registered domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

When Group Coverage Ends

(When a group chooses "date of termination" eligibility, the appropriate variables will apply (or not apply).)

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. If You lose an Enrolled Dependent, You must notify Us within 30 days.

No person will have a right to receive benefits under the Contract after the date it is terminated. Termination of Your or Your Enrolled Dependent's coverage under the Contract for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Contract was in effect.

CONTRACT TERMINATION

If the Contract is terminated or not renewed by the Group or Us, coverage ends for You and Your Enrolled Dependents on the date the Contract is terminated or not renewed.

MEMBER EMPLOYMENT TERMINATION

If Your employer ceases to be a Member Employer, coverage ends for You and Your Enrolled Dependents on the date Your employer ceases to participate under the Contract.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents' coverage ends on the date on which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, Your coverage will end for You and all Enrolled Dependents on the date on which employment ends.

NONPAYMENT OF PREMIUM

If You fail to make required timely contributions to premium, Your coverage will end for You and all Enrolled Dependents.

TERMINATION BY YOU

You have the right to terminate the Contract with respect to Yourself and Your Enrolled Dependents by giving notice to Us. Coverage will end on the date We receive such notice.

FAMILY AND MEDICAL LEAVE

If Your employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
 - in order to care for Your newly born child;
 - in order to care for Your spouse, domestic partner, child or parent, if such spouse, domestic partner, child or parent has a serious health condition;
 - the placement of a child with You for adoption or foster care; or

- You suffer a serious physical or Mental Health Condition.

During the FMLA leave, You must continue to pay the monthly premium through Your employer to the Group on time. The provisions described here will not be available if the Contract terminates or Your employer ceases to be a Member Employer.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the FMLA leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form just as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purposes of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Group must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your employer and approved by the Group, You can continue coverage for up to three months. Premiums must be paid through Your employer to the Group in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of the Group. A leave can be granted for any reason acceptable to Your employer and the Group. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Contract only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Enrolled Dependents) may reenroll under the Contract only during the next annual enrollment period.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the date in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date a divorce or annulment is final.

If You Die

If You die, coverage for Your Enrolled Dependents ends on the date on which Your death occurs.

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another Affidavit of Domestic Partnership for a non-registered domestic partner within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the date the child exceeds the dependent age limit.
- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the date the child is no longer a dependent.

OTHER CAUSES OF TERMINATION

Members may be terminated for any of the following reasons. However, it may be possible for them to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Fraudulent Use of Benefits

If You or Your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Contract will terminate for that Member.

Fraud or Misrepresentation in Application

We have issued the Contract in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding a Member (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Group), We will take any action allowed by law or Contract, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Contract should be directed to the Group, or to Us at P.O. Box 30271, Salt Lake City, UT 84130-0271.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If Your Group coverage is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You and Your domestic partner terminate the domestic partnership;
- You become entitled to Medicare benefits; or
- Your enrolled child loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Enrolled Dependents under certain conditions if You are retired and Your former employer files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules

Generally, You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Enrolled Dependent's rights under COBRA, You or Your Enrolled Dependents must inform the Group in writing within 60 days of:

- Your divorce or annulment, termination of domestic partnership or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Enrolled Dependent were disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Enrolled Dependent is no longer disabled for Social Security purposes, You or Your Enrolled Dependent must provide the Group notice of that determination within 30 days of the date it is made.)

The Group also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep Your employer and the Group informed of the current address of all Members who are or may become qualified beneficiaries.

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize Your or Your Enrolled Dependents' future eligibility for an individual plan.

Notice

The Contract includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your employer or Group.

After You and/or Your Enrolled Dependents' term of COBRA continuation coverage has been exhausted, a policy of conversion may be available.

Non-COBRA Continuation of Coverage

You and Your Enrolled Dependents are entitled to continuation of Group coverage benefits upon loss of eligibility for coverage.

The Group must notify You and Your Enrolled Dependents of this continuation right. If You and/or Your Enrolled Dependents do not receive notice, You may contact Us directly within 60 days following termination of coverage and elect continuation of coverage.

If You and/or Your Enrolled Dependents choose to continue coverage under this right, You must enroll in writing and pay the premium for such coverage within 60 days of coverage termination. You will be required to make timely premium payments to Your employer or the Group, as instructed. The Group may charge You and Your Enrolled Dependents a premium no higher than the current rate paid for coverage of a comparable Member (or Members) who lost coverage and neither Your employer nor the Group is required to make any contribution toward premiums for continuation coverage. Where an enrollment form and premium are received within the 60-day period, the accepting Member's coverage continues, without interruption, from the date the Member's coverage was terminated.

This continuation of coverage will terminate when the first of the following occurs:

- Your and/or Your Enrolled Dependents fail to make payment of premiums for the coverage as instructed and within the established timeframe;
- six months elapse; or
- the Group's coverage is terminated.

If Your employer or the Group replaces coverage with a similar plan, those who have continued coverage may obtain coverage under the replacement policy for the balance of the period that they would have been allowed to extend benefits under the replaced coverage.

If Your Group is required to offer COBRA continuation of coverage, You may continue group coverage under both COBRA and this non-COBRA continuation of coverage. In almost all cases, COBRA offers greater benefits with fewer restrictions than this continuation of coverage. However, administration will be according to whichever law offers the greatest benefit to You. The maximum number of months You may continue coverage will never be more than the number available under COBRA.

After You and/or Your Enrolled Dependents' term of continuation coverage has been exhausted, a policy of conversion may be available.

Conversion

When eligibility under the Contract terminates, and You are under age 65 and ineligible for Medicare, You will be allowed to enroll under one of Our conversion plans. To be eligible, We must receive Your application within 31 days following termination of coverage under this Contract. You will not be required to complete a health statement. The benefits of the conversion plan will be the standard individual medical and Hospital benefits coverage in effect at the date of conversion that We customarily offer to Members upon termination of coverage. It is very likely that rates under the conversion plan will be higher than for this Contract and benefits will be substantially less. Coverage under the conversion plan will be subject to the same waiting period provisions as this Contract. However, any dependents added to the conversion plan after the Enrolled Employee's Effective Date will be subject to the waiting periods of the conversion plan. By enrolling in a conversion plan, You may lose the right to enroll without submitting a health questionnaire under one of Our marketed individual plans (see the Other Continuation Options Section for additional information on individual plans).

If the Contract with the entire Group terminates and the Group transfers its health care plan to another Contract with Us, to another carrier or to a self-funded plan and You are covered under that plan, this conversion option does not apply.

Other Continuation Options

This section describes situations when coverage may also be extended for You and/or Your Enrolled Dependents beyond the date of termination.

Medicare Supplement Or Individual Contract

When eligibility under the Contract terminates, You may be eligible for coverage under an individual insurance policy or a Medicare supplement plan through Us as described here. If You choose to enroll in a conversion plan (discussed earlier), You may lose the right to enroll in one of these plans without submitting a health questionnaire.

- If You are eligible for Medicare, You may be eligible for coverage under one of Our Medicare supplement plans. To be eligible for continuous coverage, We must receive Your application within 31 days following Your termination from the Contract. If You apply for a Medicare supplement plan within six months of enrolling in Medicare Part B coverage, We will not require a health statement. After the six-month enrollment period, We may require a health statement. Benefits and premiums under the Medicare supplement plan will be substantially different from the Contract.
- If You are not eligible for Medicare, You may be eligible for coverage under one of Our individual plans. To be eligible, You must submit a completed application form and health questionnaire, if applicable, and must be accepted by Us for coverage. Benefits and premiums under the individual plan may be substantially different from the Contract.

If the Contract with the entire Group terminates and the Group transfers its health care plan to another Contract with Us, to another carrier or to a self-funded plan and You are covered under that plan, this continuation option does not apply.

Strike, Lockout Or Other Labor Dispute

If the Enrolled Employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, the Enrolled Employee may continue coverage under the Contract for himself or herself and Enrolled Dependents during the dispute for a period not exceeding six months, by paying the necessary premiums for Your coverage through the Group. This provision will not apply if the Enrolled Employee and Enrolled Dependents are eligible for COBRA.

If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full premium, including any part usually paid by Your employer or the Group, directly to the union or trust that represents You. And the union or trust must continue to pay Us the premiums according to the Contract. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Contract.

General Provisions

This section explains various general provisions regarding Your benefits under this coverage.

CHOICE OF FORUM

Any legal action arising out of the Contract must be filed in a court in the state of Washington.

ERISA (IF APPLICABLE)

This provision applies if the Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

The Group and Member Employers intend that the Contract be maintained for the exclusive benefit of the employees.

The Group and Member Employers intend to continue this coverage indefinitely, but also reserve the right to discontinue or change this coverage at any time. If the Contract is terminated for any reason and is not replaced with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

Rights and Protection

Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.
- If the plan has an exclusion period for a Preexisting Condition, reduce or eliminate periods that coverage for Preexisting Conditions is excluded, when they have creditable coverage from another plan. Group plans and health insurance issuers should provide a certificate of creditable coverage, free of charge, when an employee loses that other coverage, when he or she becomes entitled to elect COBRA continuation under it, when COBRA continuation is exhausted and if an employee requests one within 24 months after losing that other coverage. Without evidence of creditable coverage, an employee may not have coverage for Preexisting Conditions, if any, as further specified in the General Exclusions Section.

Duties

In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to Appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the plan administrator in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to \$110

a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

Denied Claims

If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting his or her rights, employees may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, he or she should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

GOVERNING LAW AND BENEFIT ADMINISTRATION

The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the State of Washington without regard to its conflict of law rules. We are not the plan administrator, but are a health care service contractor that provides health care coverage to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Member rights under this benefit plan that include the right to appeal, review by an Independent Review Organization and civil action.

GROUP IS AGENT

The Group is Your agent for all purposes under the Contract and not the agent of Asuris Northwest Health. You are entitled to health care benefits pursuant to an agreement between Us and the Group. In the Contract, the Group agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Contract. You, through the enrollment form signed by the Enrolled Employee, and as beneficiaries of the Contract, acknowledge and agree to the terms, provisions, limitations and exclusions of the Contract.

MODIFICATION OF CONTRACT

We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until 30 days after written notice has been given to the Group, and modification must be uniform within the product line and at the time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract. No modification or amendment of the Contract will affect the benefits of any Member who is, on the Effective Date of such modification or amendment, confined in a Hospital or other facility on an inpatient basis, until the first discharge from such facility occurring after such Effective Date.

NO WAIVER

The failure or refusal of either party to demand strict performance of the Contract or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Contract will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

NOTICES

Any notice to Members required in the Contract will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee will be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form (COA) for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to: Asuris Northwest Health, P.O. Box 30271, Salt Lake City, UT 84130-0271; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

PREMIUMS

Premiums are to be paid to Us by the Group, in advance, and on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's, a Member Employer's, or a Member's coverage on the last day of the monthly period through which premiums are paid or such later date as is provided by applicable law.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

WE ARE NOT RESPONSIBLE FOR HEALTH SAVINGS ACCOUNT FINANCIAL OR TAX ARRANGEMENTS

While this high deductible health plan was designed for use in conjunction with a health savings account (HSA), Asuris Northwest Health does not assume any liability associated with Your maintenance of an HSA during any period that this high deductible health plan does not qualify for use with an HSA. You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that you choose to establish and maintain.

Asuris Northwest Health assumes no responsibility for reimbursement from the custodial financial institution under any HSA with which this high deductible health plan is used.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under the Contract, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions of the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person for the current month has been paid by the Group on a timely basis.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, We will provide coverage (subject to the same provisions as any other benefit) for:

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

Definitions

The following are definitions of important terms used in this Booklet. Other terms are defined where they are first used.

Allowed Amount means:

- For preferred and participating Providers (see definitions of "Category 1" and "Category 2" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For nonparticipating Providers (see definition of "Category 3" below) the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact Us.

Affiliate means a company with which We have a relationship that allows access to providers in the state in which the Affiliate serves and includes the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Oregon in the state of Oregon and Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Ambulatory Service Facility means a facility, licensed by the state in which it is located, that is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the Group and Us.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Member's Effective Date.

Category 1 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract and an effective preferred addendum or agreement with Us or one of Our Affiliates (currently serving the states of Idaho, Oregon, Utah, and Washington) which designates him, her or it as a preferred Provider to provide services and supplies to Members in accordance with the provisions of this coverage.

For Category 1 reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Category 2 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with Us or one of Our Affiliates (currently serving the states of Idaho, Oregon and Washington) which designates him, her or it as a participating Provider to provide services and supplies to Members in accordance with the provisions of this coverage. For Category 2 reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Category 3 means the benefit reimbursement level for services that are received from a Provider who does not have an effective participating contract with Us or one of Our Affiliates to provide services and supplies to Members. This term also included reimbursement for Providers outside the area that We or one of Our Affiliates serves (outside the states of Idaho, Oregon, Utah and Washington). For Category 3 reimbursement inside the area that We or one of Our Affiliates serves, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Outside the area that We or one of Our Affiliates serves, Category 3

reimbursement will be made at the Category 1 payment level, and You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections of the Contract.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Effective Date means the date specified by Us, following Our receipt of the enrollment form, as the date coverage begins for You and/or Your dependents.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Member's health, or with respect to a pregnant Member, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

Enrolled Employee means an employee of a Member Employer who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage.

Essential Benefits are determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include at least the following general categories and the items and services covered within the categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

Family means an Enrolled Employee and his or her Enrolled Dependents.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, illness, injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more

Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder (which is otherwise defined in this Booklet).

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Investigational means a Health Intervention that We have classified as Investigational. We will review Scientific Evidence from well-designed clinical studies found in Peer-Reviewed Medical Literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria, is, in Our judgment, Investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-Reviewed Medical Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:
 - Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
 - Standard Reference Compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Upon receipt of a fully documented claim or request for preauthorization related to a possible Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Please contact Us by calling Our Customer Service department at 1 (877) 508-7361. or by visiting Our Web site at www.myAsuris.com for details on the information needed to satisfy the fully documented claim or request requirement. You may also have the right to an expedited Appeal. Refer to the Appeal Process Section for additional information on the Appeal process.

Lifetime means the entire length of time a Member is covered under the Contract (which may include more than one coverage) through the Group with Us.

Maintenance Therapy means a Health Intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed. This is particularly applicable to patients with chronic, stable conditions where skilled supervision/intervention is no longer required and further clinical improvement cannot reasonably be expected from continuous ongoing care. This includes but is not limited to:

- a general exercise program to promote overall fitness;
- ongoing treatment solely to improve endurance and fitness;
- passive exercise to maintain range of motion that can be carried out by non-skilled persons;
- programs to provide diversion or general motivation;
- therapy that is intended to maintain a gradual process of healing or to prevent deterioration or relapse of a chronic condition; or
- therapy that is supportive rather than corrective in nature.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider, and not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors. (If "Medically Necessary" or "Medical Necessity" is specifically defined in any benefit under the Medical Benefits section of this Booklet, such definition shall be applicable for purposes of that benefit instead of this definition.)

Member means an Enrolled Employee or an Enrolled Dependent.

Member Employer means a business entity qualifying for membership or participation in the Group and choosing to participate under the Contract to provide coverage to its employees and their dependents as Enrolled Employees and Enrolled Dependents, respectively.

Physician means an individual who is duly licensed as a doctor of medicine (M.D.), doctor of osteopathy (D.O.) or doctor of naturopathic medicine (N.D.) who is a Provider covered under the Contract.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and other professionals practicing within the scope of his or her respective licenses.

Provider means a Hospital, Skilled Nursing Facility, ambulatory services facility, Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive,

multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Service Area means the state of Washington. Please check Our Web site at **www.myAsuris.com** for up-to-date information.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

**For more information call us at 1 (888) 367-2109 or you can write
to us at 528 E Spokane Falls Blvd., Suite 301, Spokane, WA
99202**

Program provided by:

Wells Fargo Insurance Services USA, Inc.
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