



WEA
WASHINGTON
EDUCATION
ASSOCIATION

Premera Blue Cross

Select Plan 2

Network: Heritage

October 1, 2003

IMPORTANT NOTE

Payment for covered services is subject to the Allowable Charge (see Definitions).

In order for available benefits to apply, all services, with the exception of the “Preventive Medical Care Benefit,” must meet all of the following requirements:

- They must be, in the judgment of Premiera Blue Cross, medically necessary and must be furnished in a medically necessary setting.
- They must be furnished in connection with the diagnosis or treatment of a covered illness or accidental injury.
- They must be prescribed and furnished by a physician or other covered provider within the scope of his or her license or certification.
- They must not be excluded from coverage under this program.
- Expenses must be incurred while the enrollee is covered under this program and after any applicable waiting period required under this program is satisfied.
- The fact that services are prescribed, approved, or furnished by a physician or other qualified provider does not, in and of itself, mean that such services are medically necessary or are covered benefits.

**WASHINGTON EDUCATION ASSOCIATION
SELECT MEDICAL PLAN 2**

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We appreciate hearing from you about ways we can improve our service. If you have an idea or suggestion, or wish to express your opinion on any aspect of your coverage with us, please call the WEA Select Service Team at:

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357 **Please Note:** Only calls from the hearing-impaired will be accepted on this line.

Or write to us at:

Administrator, Service Quality Assessment
Premera Blue Cross
P.O. Box 327
Seattle, WA 98111-0327

INTRODUCTION

Your WEA Select Medical Plan was designed specifically for school employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Consulting (Employee Benefits Consultant), Premiera Blue Cross (Medical Plan Underwriter) and UnumProvident Life and Accident Insurance Company (Life Insurance Underwriter).

The WEA is the policyholder for this program of medical benefits. The WEA retains full and exclusive authority, at its discretion, to determine the availability of this program. The program is not guaranteed to continue indefinitely. The program may be altered or terminated at any time.

All program benefits and limitations are reviewed by the WEA Benefits Services Advisory Board and approved by the WEA Board of Directors. Your suggestions for program improvements are always welcome and may be forwarded to the WEA or Aon Consulting.

In order to understand how your benefits are paid, it is suggested that you review this booklet at the time of enrollment. As medical expenses are incurred, you may wish to review the section which applies to those specific types of expenses.

Premiera Blue Cross has a WEA Select Service Team who serve WEA Medical Plan enrollees. Please call one of the following numbers if you have questions on coverage or claims:

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357 **Please Note:** Only calls from the hearing-impaired will be accepted on this line.

We are all aware that health care costs are continuing to rise and are reflected in our medical rates. We can help control costs by working together. The WEA Select Medical Plan is designed to encourage efficient use of healthcare services. You can help limit healthcare cost increases by taking the following simple steps to avoid costly medical care and take full advantage of your benefits:

- When hospital or medical services are necessary, seek care from a Heritage Provider whenever possible.
- Seek medical help in a physician's office rather than the emergency room of a hospital whenever possible.
- Receive treatment for simple surgeries, diagnostic and preadmission tests on an outpatient basis or in the physician's office whenever possible.

Throughout the booklet, we use many terms that have specific meaning under this program. These are defined in the "Definitions" section of this booklet. The terms "you" and "your" refer to the enrollees under this program. The terms "we," "us," and "our" refer to Premera Blue Cross.

Group Name WASHINGTON EDUCATION ASSOCIATION
Plan Year October 1, 2003 - September 30, 2004

Group Number WEA Select Medical Plan 2
Contract Form Number 1223X

SUMMARY OF BENEFITS

Select Medical Plan 2

Revolving Five-Year Maximum \$5,000,000

Specific Benefits - Section I (Description Of Benefits Starts On Page 23)

The following benefits are not subject to your program's General Benefits Reimbursement Formula, nor are they subject to your program's revolving five year maximum:

Physician Home And Office Visit Benefit

Paid in Full** After:

Heritage Providers\$25 copayment
Non-Heritage Providers\$30 copayment
(applies to the charge for the home and office visit only)

Naturopathic Services

Paid in Full** After:

Heritage Providers\$25 copayment
Non-Heritage Providers\$30 copayment

Acupuncture Services

Paid in Full** After:

Heritage Providers\$25 copayment
Non-Heritage Providers\$30 copayment
up to 12 visits per calendar year

Preventive Medical Care Benefit

Limited to \$200 per enrollee each calendar year

(well-baby to \$500 per enrollee per calendar year from birth through age 3)

Heritage Providers paid at 100%**

Non-Heritage Providers paid at a constant 80%**

Stop Smoking Benefit Constant 50%
(\$250 lifetime maximum)

Prescription Drugs

Retail Pharmacy Drug Benefit

\$7 copayment for Generic Drugs

\$20 copayment for Preferred Brand List Name Drugs

\$30 copayment for Non-Preferred List Brand Name Drugs

Home Delivery Pharmacy

\$10 copayment for Generic Drugs

\$15 copayment for Preferred Brand List Name Drugs

\$25 copayment for Non-Preferred List Brand Name Drugs

(See page 26)

Home Health Care Benefit See Page 29
(Subject to a \$50 annual copayment, for non-custodial care)

Hospice Care Benefit Paid in Full**
(Subject to a \$50 annual copayment; 6-month lifetime maximum;
inpatient - up to 10 days;
respite care - up to 120 hours per 3-month period)

Skilled Nursing Facility Benefit See Page 31
(Subject to a \$50 annual copayment, for non-custodial care)

Voluntary Second Surgical Opinion Benefit Paid in Full**

Outpatient Rehabilitative Therapy And Neurodevelopmental Therapy Benefit

Outpatient Rehabilitative Therapy

Paid in Full** after a \$25 copayment for services rendered by a Heritage provider or a \$30 copayment for services rendered by a Non-Heritage provider up to 45 visits per calendar year

Outpatient Neurodevelopmental Therapy

Up to \$30 of allowable charges per day for up to 45 visits per calendar year

Audio Benefit Constant 80%**
(Up to \$400 maximum each three consecutive calendar years)

Nonsurgical Treatment Of Morbid Obesity Constant 50%**
(\$750 lifetime maximum)

Specific Benefits - Section II
(Description Of Benefits Starts On Page 34)

The following benefits are not subject to your program’s General Benefits Reimbursement Formula, but they are subject to your program’s revolving five-year maximum:

Mental Health Benefit

Inpatient Mental Health

Subject to the inpatient hospital copayment

Constant 80%** for Heritage and Non-Heritage Providers

Outpatient Mental Health

(limited to 50 one-hour visits per calendar year)

Heritage Providers Constant 70%**

Non-Heritage Providers Constant 50%**

Nonsurgical Treatment Of TMJ Dysfunction Constant 50%**
(lifetime maximum \$1,000)

General Benefits - Section III
(Description Of Benefits Starts On Page 36)

The following benefits are subject to your program’s revolving five-year maximum:

(Applies to all covered charges except those included under Specific Benefits)

General Benefits Reimbursement Formula

Heritage Providers 80% of Allowable Charges**

Non-Heritage Providers 60% of Allowable Charges**

The General Benefits Reimbursement Formula (GBRF) is the percentage of allowable charges paid by Premiera Blue Cross. After the plan pays \$5,500 in benefits for covered services per enrollee (combined for Heritage and Non-Heritage providers), benefits will be paid at 100% of the allowable charge for covered services for the remainder of that calendar year.

General Benefits With Specific Benefit Levels Or Maximums

Treatment Of Chemical Dependency*	Up to \$11,285 in a 24-consecutive month period
Inpatient Rehabilitative Care*	Up to 120 Days Each Calendar Year
Inpatient Neurodevelopmental Therapy*	Up to 120 Days Each Calendar Year
Transplants*	Up to \$250,000 Lifetime Maximum
Private Duty Nursing	Up to \$5,000 Each Calendar Year

***IMPORTANT: Hospital inpatient services are subject to a \$150 copayment per enrollee per day up to a maximum of \$450 per enrollee per calendar year.**

Outpatient surgery services are subject to a \$100 copayment.

****Please Note: Payment of benefits for covered services is based on what Premiera Blue Cross considers to be "allowable charges," not to exceed actual charges by a provider of service. For a complete explanation of allowable charges, please see the "Definitions" section.**

WHO IS COVERED AND WHEN

EMPLOYEES

An employee is eligible if he or she is a WEA member and employed at least 17.5 hours per week as an employee of any division of the Washington Public Schools, or the WEA and its Affiliates. If the participating employer group makes a contribution toward the cost of coverage under this program, the WEA membership requirement and 17.5 hours per week requirement will be waived.

To continue eligibility during a school year, an employee who is a senior substitute teacher must remain in the substitute pool and maintain classification as a senior substitute teacher. Senior substitute teachers are those who have continuously worked as a substitute or regular teacher, as defined by the district.

School board members are not eligible for coverage unless they are paid employees of the school district and meet the standard WEA eligibility requirements. School board members who receive compensation for their services as board members are not considered employees for this purpose.

Enrollment forms may be obtained from your school district's business office. Complete and return a Premier Blue Cross enrollment form to your school district's business office. You must enroll within 30 days of hire or at the annual open enrollment period (see page 11 for additional information).

Coverage begins on the first of the month following the date of enrollment provided subscription charges are remitted on a timely basis.

DEPENDENTS

Dependents will have the same effective date as the employee (except those acquired after the effective date), provided proper application has been made. Eligible dependents are:

- The lawful spouse.
- The lawful unmarried children under age 23, if they are primarily dependent on the subscriber. ("Children" includes the subscriber's or spouse's natural child, adopted child, or child placed with the subscriber in accordance with state law for the purpose of legal adoption. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child.)

A lawful unmarried child over age 23 incapable of self support due to a physical or developmental disability will be considered an eligible dependent when all of the following requirements are met:

- The child is incapable of self sustaining employment due to a developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance.
- The subscriber completes a "Request for Certification of Handicapped Dependent" form. We must approve the request for certification. If the subscriber is requesting continuation of coverage for a disabled child past age 23, the certification form must be provided to us within 31 days of the child reaching the limiting age. An overage disabled child that is enrolling on the same date as the subscriber also requires approval from us.
- The subscriber provides us with proof of the child's disability and dependent status when we request it. We will not ask for proof more often than once a year after the two-year period following the child's 23rd birthday.
- The subscriber must provide proof of continuous group coverage for the disabled dependent.

Please Note: The subscriber and disabled child must maintain concurrent coverage under this program.

- A legally placed ward of the subscriber or spouse living permanently in the home of the subscriber.

NATURAL NEWBORN CHILDREN

Children of the subscriber or spouse born while the subscriber is covered under this program are covered from date of birth if enrolled for coverage within 60 days of birth. They will receive the same medical benefits as your other dependents as well as benefits for prematurity and congenital defects. To enroll a newborn, please submit a Premier Blue Cross enrollment form to your payroll office. If the subscription charges being

paid on behalf of the subscriber already include coverage for dependent children, a new enrollment application is not required. However, you must advise us of your desire to enroll your newborn child within the 60-day period. If an additional subscription charge is required, it will begin on the first billing cycle following date of birth.

Newborns will be automatically covered for three weeks following the date of birth when the mother is enrolled on this program and receiving maternity benefits. When the mother is not enrolled, or the parents wish to enroll the child beyond the three-week period, the enrollment guidelines above must be followed.

If we do not receive the application or notification within the 60-day time period for eligibility, the child may not enroll until the next open enrollment period. The only exception is explained under "Loss Of Other Coverage."

ADOPTIVE CHILDREN

Children placed for adoption with the subscriber on or after the subscriber's effective date are covered from the date of placement if enrolled for coverage within 60 days of placement. To enroll an adopted child, please submit a Premera Blue Cross enrollment form and copies of the adoption documents to your payroll office. If the subscription charges being paid on behalf of the subscriber already include coverage for dependent children, a new enrollment application is not required. However, the subscriber must submit copies of the adoption documents within the 60-day period.

Please contact a WEA Customer Service Representative at 1-800-722-1471 for information on the appropriate documents needed by Premera Blue Cross for the addition of your newly adopted child.

If an additional subscription charge is required, it will begin on the first billing cycle following the date of placement.

If we do not receive the application and/or the adoption documents within the 60-day time period for eligibility, the child may not enroll until the next open enrollment period. The only exception is explained under "Loss Of Other Coverage."

LEGAL GUARDIANSHIP/NON-PARENTAL CUSTODY

Children under legal guardianship (legal wards) or under a legal non-parental custody decree may be enrolled for coverage if the following conditions are met:

- The legal guardianship/non-parental custody must have been awarded in accordance with the laws of the state in which the guardianship/non-parental custody is obtained. Documentation must be provided, including the court order and petition for guardianship/non-parental custody, stating the reason and authority of the guardianship/non-parental custody.
- The guardian/person with non-parental custody must be either the subscriber or the subscriber's spouse. The guardian/person with non-parental custody and the child must both be enrolled under the same program.
- The child must be under 23 years old and single.
- The child must have been placed in the subscriber's home under a parent-child relationship.
- The guardian/person with non-parental custody must provide the main support for the child, outside of federal or state support.

When a completed enrollment application is received for a child covered under legal guardianship (legal wards) or under a legal non-parental custody decree within 60 days of the date of that decree, coverage for an otherwise eligible child that is required under the decree will become effective on the date of the decree.

If we do not receive the application within the 60-day time period for eligibility, (child/spouse) may not enroll until the next open enrollment period. The only exception is explained under "Loss Of Other Coverage" on page 11.

MARRIAGE

Application for the addition of a spouse and children newly acquired through marriage must be made within 60 days of marriage. Upon timely receipt of the completed enrollment application and required subscription charges, if any, coverage will begin on the first day of the first billing cycle following the date of marriage.

If we do not receive the application within the 60-day time period for eligibility, (child/spouse) may not enroll until the next open enrollment period. The only exception is explained under "Loss Of Other Coverage" on page 11.

MEDICAL CHILD SUPPORT ORDERS

When a child is to be added to a subscriber's coverage due to a medical child support order, we must receive a copy of the court order (or National Medical Support Notice, Part B) with the completed enrollment application. When we receive these documents within 60 days of the date of that order, coverage for an otherwise eligible child that is required under the order will become effective on the subscriber's coverage as of the date of the order. Coverage under the subscriber's plan will be effective as of the subscription charge due date that coincides with, or next follows, the date of application for coverage. The application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid, or the state child support enforcement agency. When subscription charges being paid do not already include coverage for dependent children, they will begin the first billing cycle following the date of the court order.

SURVIVING DEPENDENTS

If an enrolled subscriber dies, the medical coverage under this program will be continued for enrolled surviving dependent(s) without a subscription charge for a period of up to 12 months following death of the subscriber. This coverage will only be provided for dependents who were enrolled under this program at the time of the subscriber's death and will be secondary to the coverage of any other group program subject to the Coordination of Benefits provision stated elsewhere in this benefit booklet. Please notify your school district's business or payroll office within 30 days with this information. This 12-month period will apply toward your COBRA continuation period, if elected, and will not extend any other continuation benefits your employer may offer.

Dependents must continue to meet the eligibility requirements as defined under "Who is Covered and When." Surviving dependents who become ineligible for coverage during the 12-month extension of benefits following the subscriber's death may apply for COBRA and the monthly subscriber charge waiver will no longer apply.

CHANGE IN FAMILY STATUS

Should the number of your family members change, please request a new application form, fill it out, include all eligible dependents, and return it to your school district's business office following the change in status.

Refunds due, based on a change in status, will not exceed 60 days from the date such change is reported to Premera Blue Cross. Premera Blue Cross will have the right to recover any benefits paid in error.

When a family member ceases to be eligible on your medical group coverage, he or she may continue health care protection on one of our Premera Blue Cross Group Conversion programs, or through "Continuation Of Group Coverage - COBRA" (see page 13). If the dependent becomes eligible for Medicare coverage, he or she can apply for coverage on a Premera Blue Cross program designed to supplement Medicare. However, you must meet the other eligibility requirements of the non-group program.

If you or your dependent becomes eligible for Medicare, please notify your Payroll Office within 60 days in order to learn how your benefits are affected.

LOSS OF OTHER COVERAGE

You and your dependents may be enrolled on this program outside the open enrollment period if you had other health care coverage at the time this program was offered, but later lose that coverage.

- The loss of the other coverage **must** be due to one of the following events:
 - Loss of eligibility due to legal separation, divorce, death, end of employment, retirement, or a reduction in the number of hours you are employed;
 - The employer terminates its contribution toward the coverage; or
 - You were covered under COBRA and that COBRA coverage has been exhausted.

If you or your dependents lose coverage due to any other reason, you will have to wait until the next open enrollment period to enroll.

You must provide us with a written statement with the reason you declined this program when it was last offered to you. We must receive your application and monthly payment within 60 days of the date the prior coverage ended. Coverage on the program will begin on the first of the month after we receive your application.

OPEN ENROLLMENT

If your school district offers employees a choice of another medical care program, subscribers and dependents enrolled on the participating employer group's other program may transfer to this program **only** during the participating employer group's scheduled open enrollment period.

Eligible employees and/or dependents who are not enrolled on this medical program or any other medical program offered by the participating employer group may be enrolled during their scheduled open enrollment period, except as described below.

Enrollment at any other time will be allowed **only** as explained under "Loss Of Other Coverage," "Marriage," "Natural Newborn Children," "Adoptive Children," "Legal Guardianship/Non-parental Custody," "Medical Child Support Orders," or "Subscriber and Dependent Special Enrollment."

SPECIAL ENROLLMENT FOR SUBSCRIBER AND DEPENDENTS

You and/or your dependents may enroll on this program outside the open enrollment period when **both** of the following requirements are true:

- You are enrolling a new dependent acquired through marriage, birth, adoption, assumption of legal guardianship, non-parental custody, or due to a medical child support order as described in this section; and
- You and your dependents did not enroll in **any** school-district health care program when it was offered to you during the open enrollment period.

The eligible employee may also choose to enroll without enrolling any eligible dependents. We must receive your application and any required monthly payment within 60 days of the date of the marriage, birth, adoption, or court order. If we do not receive the application within the 60-day limit, you may not enroll until the next open enrollment period. The date your coverage begins will depend upon the event which allowed you to enroll. In the case of birth, adoption, legal guardianship, or a medical child support order, coverage begins on the date of the event. In the case of marriage, coverage will begin on the first of the month following the date of marriage.

WHEN YOU BECOME AGE 65

AND CONTINUE EMPLOYMENT AS AN ACTIVE EMPLOYEE

If you are either an active employee or an active employee's covered spouse and are age 65 or over, this WEA Select Medical Plan will provide primary coverage and your Medicare coverage will be secondary.

SELF-PAYMENT PROVISIONS

Labor Dispute

If compensation is suspended directly or indirectly as a result of strike, lockout or other labor dispute, subscription charges may be paid for yourself and your eligible dependents directly to the employer for up to six months. See "Continuation Of Group Coverage - COBRA" and "Converting To A Nongroup Program" for continued health care coverage when the six-month period ends. This period of coverage will not extend any other period of continued coverage provided by your program.

When the subscriber's compensation or wage is so suspended or terminated, the subscriber shall be notified immediately in writing by the Participating Employer Group. A notice will be mailed to the address last on record with the participating employer group, that the subscriber may pay subscription charges to the participating employer group as they are due as provided in this section.

Leave Of Absence

Coverage for the subscriber and any enrolled dependents on an official leave of absence or sabbatical may be continued for up to 18 months. The leave of absence time period must begin at the end of the last month of coverage paid from fringe benefit funds earned during active employment. If you do not elect continued coverage at this time, or if you terminate coverage at any time during your leave of absence, you may not enroll on the plan until you return to active employment. If you do not elect coverage under the leave of absence provision, or terminate coverage during your leave of absence, you will immediately become eligible for COBRA. To be eligible for COBRA, you must elect coverage under COBRA within 60 days after coverage under the leave of absence provision terminates.

A district approved leave beyond 18 months does not entitle the subscriber (or enrolled dependents) to extend coverage under this leave of absence provision. If your leave extends beyond this 18 months of continued coverage, you and your enrolled dependents may be eligible for an additional 18 months of continued coverage through "Continuation of Group Coverage - COBRA" (see below). If you do not return to work after your leave of absence or if another consecutive district-approved leave is granted without another period of active employment, "Continuation of Group Coverage - COBRA" will also be available.

The maximum period of extended coverage under any circumstance is 36 months, i.e., up to 18 months of continued coverage under the leave of absence provision and up to 18 months of COBRA continuation.

Additional coverage under this provision may be elected if you return to employment and are granted further official leaves of absence or sabbaticals.

Example:

- Employee is granted a leave of absence and is no longer actively at work as of March 20.
- Employee's active work results in fringe benefit dollars for March, which pay for April benefits.
- Employee will receive sick leave through the district leave sharing program for 2 months.

In the above example, the 18-month leave of absence coverage period would officially begin on May 1, because April is the last month of fringe benefit funds from active employment. The total extended coverage for sick leave and the leave of absence would be 18 months, at which time the district would need to provide the employee notice of access to COBRA continuation for 18 additional months (total 36 months). If the above leave of absence had been started prior to the March payroll cutoff for benefits, the leave period would begin April 1.

Dependents may not be added while the subscriber is covered during this time; however, newly acquired dependents may be added if they meet the eligibility and enrollment requirements of this plan.

Employer-paid continuation of coverage may be available for up to 12 weeks in the event of leave covered under the Family and Medical Leave Act of 1993. Please check with your school district's payroll office for additional information.

Reduction In Force

For those participating employer groups who do not provide "Continuation Of Group Coverage - COBRA" under this program, the following provision will apply:

Coverage for Reduction In Force (RIF) subscribers and their enrolled dependents may be continued on a self-paid basis through the group for up to 12 months from date of lay-off.

Continuation Of Group Coverage - COBRA

For participating employer groups with 20 or more employees (as described by COBRA)

When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations require the participating employer group to offer qualified enrollees an election to continue their group coverage for a limited time. (These laws and regulations are referred to in this program as "COBRA.") Continued coverage is not automatic. Under COBRA, a qualified enrollee must apply for continued coverage within a certain time period and may also have to pay the subscription charges for it.

The participating employer group must fulfill all of the obligations and responsibilities regarding continued coverage that are assigned by COBRA to the participating employer group, plan sponsor or administrator, and to the "group health plan." Premera Blue Cross is not the COBRA plan administrator, and our actions pertaining to COBRA continued coverage under this contract shall not be construed as relieving the participating employer group of its responsibility under COBRA. We provide coverage only to the extent that enrollees are entitled to continued coverage under COBRA and only to the extent of the other terms and limitations of this contract.

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

Qualifying Events and Length of Coverage: Please contact the participating employer group immediately when one of the qualifying events below occurs. The continuation periods listed extend from the date of the qualifying event.

- The participating employer group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of one of two qualifying events:
 - The subscriber's work hours are reduced.
 - The subscriber's employment terminates, except for discharge due to actions defined by the participating employer group as gross misconduct.

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

COBRA coverage can be extended if an enrollee who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination. To be eligible for the extended continuation period, you must give the Group a copy of the determination of disability during the 18-month continuation period and no later than 60 days after you receive the determination.

- The participating employer group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of one of four qualifying events:
 - The subscriber dies.
 - The subscriber and spouse legally separate or divorce.
 - The subscriber becomes entitled to Medicare.
 - A child loses eligibility for dependent coverage.

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. The extended period will end no later than 36 months from the date of the first qualifying event.

A covered spouse or child is eligible for continued coverage due to a divorce, legal separation, or a child's loss of dependent eligibility only if the participating employer group is notified no more than 60 days after either the qualifying event date or the date the dependent's coverage ends, whichever is later.

Adding Family Members: Eligible family members may be added after the continuation period begins, but only as allowed under "Special Enrollment For Subscribers and Dependents" or "Open Enrollment" in the "Who Is Covered And When" section. With one exception, family members added after COBRA begins are not eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under "Qualifying Events And Lengths Of Coverage" earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. Continued coverage is subject to all other terms and limitations of this program.

Conditions Of Continued Coverage: For continued coverage to become effective, all of the requirements below must be met:

1. You must notify the participating employer group if the "qualifying event" is a legal separation or divorce, or a child's loss of eligibility for dependent coverage.
2. You must elect continued coverage no more than 60 days after either the date coverage was to end because of the qualifying event, or the date the participating employer group notified you of your right to elect continued coverage, whichever is later.
3. You must send your first subscription charge payment to the participating employer group no more than 45 days after the date you elected continued coverage.
4. Subsequent subscription charges must be paid on a timely basis to the participating employer group and submitted to Premera Blue Cross with the participating employer group's regular monthly billings.

When Continued COBRA Coverage Ends

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

1. The applicable continuation period expires.
2. The next monthly subscription charge is not paid when due or within the grace period.
3. If you have extended COBRA coverage due to disability, it will end if Social Security determines that you are no longer disabled. In this case, coverage terminates at the end of the month that begins at least 30 days after Social Security's decision. For example, if Social Security decides on March 15 that you are not disabled, your coverage would end May 31. You must provide the participating employer group a copy of the determination within 30 days after the date of the determination.
4. You become covered under another group health care program after the date you elect COBRA coverage. If, however, the new program contains an exclusion or limitation for your preexisting condition, coverage does not end for this reason until the exclusion or limitation no longer applies.
5. You become entitled to Medicare after the date you elect COBRA coverage.
6. The participating employer group ceases to offer this WEA Select Medical Plan to any employee in your bargaining unit/employee classification. However, you should contact your participating employer group regarding participation in any other group health plan offered to your bargaining unit/employee classification.

However, even if one of the events above has not occurred, continued coverage under this program will end on the date that the contract between the WEA and Premera Blue Cross is cancelled.

When continued coverage under this program ends, you may be eligible to apply for nongroup medical coverage as explained in "Converting To A Nongroup Program."

Applications for nongroup medical coverage may be submitted up to 180 days before the date continued coverage ends. However, Premera Blue Cross will not consider you eligible if Premera Blue Cross receives your application for nongroup coverage more than 31 days after the date your continued coverage ended. Please see "Converting To A Nongroup Program" for details on other eligibility requirements.

WHEN YOUR COVERAGE ENDS

Coverage for the subscriber and all dependents under this medical program will stop at the end of the period for which the appropriate subscription charges were paid, or if one of the following occurs:

Subscriber And Dependents:

- The subscriber ceases to meet the eligibility requirements.
- The subscriber goes beyond an approved leave of absence or sabbatical.
- The subscriber is no longer employed by or connected with the participating employer group, or the participating employer group no longer participates in this program.
- The next monthly subscription charge is not paid when due or within the grace period.
- The contract between the WEA and Premera Blue Cross is cancelled.

Spouse:

- His or her marriage to the subscriber terminates due to divorce or annulment or, if earlier, when the subscriber is no longer legally responsible for covered expenses incurred by the spouse.
- The subscriber dies or is no longer covered under this program. (See "Coverage For Surviving Dependents.")

Dependent Child(ren):

- Reaches the age of 23 (unless developmentally disabled or physically handicapped - See "Who Is Covered And When.")
- Marries.
- The subscriber dies or is no longer covered under this program. (See "Coverage For Surviving Dependents.")

If the subscriber ceases to be employed by or eligible for coverage with the participating employer group or a family member ceases to be eligible, medical coverage shall cancel automatically without notice at the end of the period for which subscription charges have been appropriately paid. Refunds due, based on a change in status, will not exceed 60 days from the date such change is reported to Premera Blue Cross. See "Continuation Of Group Coverage - COBRA" and "Converting To A Nongroup Program" for continued health care benefits.

Certificate Of Prior Group Health Coverage

When your coverage through the participating employer group's health plan terminates, including COBRA, the participating employer group will provide you with a "Certificate of Group Health Coverage." The certificate will provide information regarding your coverage under the participating employer group's health plan. When you provide a copy of the certificate to your new health plan, you may receive credit toward any preexisting condition waiting period. You will need a certificate each time you leave a health plan and enroll in a plan that has a preexisting condition waiting period. Therefore, it is important for you to keep the certificate in a safe place. If you have not received a certificate, or have misplaced it, you have the right to request one from the participating employer group within 24 months of the date your coverage terminated.

When you receive your Certificate of Group Health Coverage, make sure the information is correct. Contact the participating employer group if any of the information listed is not accurate.

Please note that when you transfer to a WEA health care plan from any other plan sponsored by another group, prior coverage may not reduce the waiting period for organ and bone marrow transplants. Please see "Organ and Bone Marrow Transplant" on page 43 for additional information.

Program Transfers

Transfer Provision

If the participating employer group offers employees a choice of another WEA Select health care program with Premera Blue Cross, the participating employer group may allow subscribers and their enrolled dependents to transfer coverage from one program to another during an open enrollment period for this program, or on another date designated by Premera Blue Cross. Transfers may also occur if the participating employer group replaces a WEA Select health care program with another WEA Select health care program.

When you transfer from any WEA Select plan to another WEA Select plan, with no lapse in coverage, amounts credited toward your coinsurance maximum or benefit maximums under the other program will also apply to this program's applicable coinsurance maximum or benefit maximums including the lifetime maximum. If the group or member changes coverage from one plan to another, a new 12-month organ transplant waiting period will not be required.

HMO Option

If the participating employer group offers employees a choice of another health care program through an HMO, employees who have elected coverage through an HMO may change coverages and enroll under this program only during an open enrollment period which is approved by Premera Blue Cross, or if they move outside of the HMO service area, or if we withdraw HMO coverage from a service area.

Contract Replacement

When the contract, of which this program is a part, replaces another contract between the WEA and Premera Blue Cross with no lapse in coverage, any waiting period required by this program will be reduced by the length of time you were continuously covered under the other program. Amounts credited toward your coinsurance maximum or benefit maximums under the other program will also apply to this program's applicable coinsurance maximum or benefit maximums, including your lifetime maximum.

Converting To An Individual Program

When your coverage under this group program or Continuation of Group Coverage - COBRA ends, you may enroll in one of the following:

Individual

You may wish to consider application for enrollment under one of the Premera Blue Cross Individual Medical programs (available to persons under age 65).

Conversion

Premera Blue Cross Conversion Programs are available to enrollees not eligible for Medicare. Health statements are **not** required for acceptance onto any of the conversion programs. **Please Note:** Enrollment on a conversion plan may limit your ability to later purchase an individual plan without a preexisting condition waiting period. Contact the nearest Premera Blue Cross office for information.

You must apply and submit the required payment for the Conversion coverage within 31 days after the date you become ineligible for this medical program.

Medicare Supplement Coverage

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you **may** be eligible for guarantee-issued coverage under certain Medicare supplement plans if you apply within 63 days of losing coverage under this plan.

The subscription charges and benefits of these programs may differ from this medical program. For specific information on subscription charges and benefits, contact your local Premera Blue Cross office.

When You Retire

The above options are available to you as stated under "Converting To A Nongroup Program." Plans are also available to retirees through the Public Employees Benefits Board (PEBB) and administered by the Washington Health Care Authority (HCA). Call 1-800-200-1004 for further information.

SPECIAL FEATURES OF YOUR PROGRAM

The Heritage Provider Network

Answers to frequently asked questions:

Question

Does my plan require me to use certain providers?

Answer

The WEA Select Medical Plan takes advantage of Premiera Blue Cross's Heritage network of providers which is similar to the "PPO" network the WEA Plan used in the past. Most of the plan's benefits are paid at a higher "in-network" benefit level when you use the services of Heritage providers. Heritage providers will also submit claims directly to us for processing.

On many benefits, you have the option to use any provider, including those who are not part of our Heritage network. In most cases, these services from Non-Heritage providers are paid at a lower, "out-of-network" benefit.

Question

Why aren't all physicians, anesthesiologists, laboratories, etc., part of the Heritage network?

Answer

Participation by providers in our networks is always voluntary. Participation in a provider network sometimes offers the provider a trade-off: if the providers will accept a discounted fee, we will direct patients to them. However, as a Heritage Plus 1 enrollee, you may access Non-Heritage providers but benefits are paid at a lower, "out-of-network" level.

Although we are constantly working to expand our provider networks, there are certain types of providers and providers in certain locations where the above concept doesn't work. In those instances, employer and consumer pressure can help persuade providers to participate in their efforts to provide health care at a reasonable cost.

Question

Are there any situations in which Non-Heritage providers receive the in-network level of benefits?

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

The following services and/or types of providers will always be covered at the highest applicable in-network benefit level, applied to the "allowable charge" for covered services and supplies (please see the "Definitions" section in this booklet):

- Emergency care. If you have a "medical emergency" (please see the "Definitions" section in this booklet), your plan provides worldwide coverage.
- Certain types of providers (including alcohol treatment facilities, blood banks and ambulance companies) with whom we have no agreements. These types of providers are not included in our provider directories.
- Services associated with admission by a Heritage provider to a Heritage hospital that are provided by hospital-based providers.

- Facility and hospital-based provider services at any of our Heritage hospitals if you are admitted by a provider who has a provider agreement with us who doesn't have admitting privileges at one of our network hospitals.

Your choice of a particular provider may affect your out-of-pocket costs because different providers may have different allowable charges even though they have a contracting agreement with us. You will never have to pay more than your share of the allowable charge when you use providers who have contracting agreements with us.

Important Note: You are entitled to receive a provider directory automatically, without charge. The directory is available on our Web site or by contacting the WEA Select Service Team. For the most current information on Heritage Providers, please refer to our Web site at www.premera.com/wea or contact the WEA Select Service Team. If you are outside Washington and Alaska, call 1-800-810-BLUE (2583) to locate a preferred provider.

Question

Why is the Heritage provider network a win-win situation for subscribers, the WEA, and contracting providers?

Answer

As a subscriber, you win with:

- Access to a large and comprehensive network of providers encompassing most medical specialties.
- Higher benefit levels when using the service of a Heritage provider.
- No claim forms needed when using the services of Heritage providers, and the providers bill Premera Blue Cross directly.
- No balance billing for charges over allowable charges.
- Freedom of choice - it's always your choice. Even if you choose a provider who is not part of our Heritage network, you will receive benefits for most services.

The WEA wins with:

- Considerable savings from contracts with Heritage providers allowing for lower rates and enhanced benefits for its enrollees.
- A cooperative provider arrangement that assures provider assistance with hospital admissions and care management.

Heritage providers win with:

- Increased patient volume.
- Increased cash flow.
- Prompt payment.

Question

How are providers paid for covered services?

Answer

Providers who have any contracting agreement with Premera Blue Cross will seek payment from Premera Blue Cross when they furnish covered services to you. You will be responsible only for any applicable copayments, coinsurance, charges in excess of the stated benefit maximums and charges for services or supplies not covered under this program.

Providers with contracting agreements with us will not bill you for amounts over our allowable charge. The benefit level (percentage of the allowable charge we pay the provider) depends on whether or not your provider is part of our Heritage provider network. In most cases, you will receive a lower benefit if you see providers who are not part of our Heritage network.

Question

If I use a provider who is not part of the Heritage network, how can I determine, in advance, if their charges are within Premera Blue Cross's allowable charge?

Answer

Ask your provider for the name of the medical procedure(s) to be performed, the procedure code number(s) and proposed fee for each service. Then call the WEA Select Service Team at Premera Blue Cross. The customer service representative will tell you if the charges are within the allowable charge and if not, the amount the fee exceeds our allowable charge. Please see the "Definitions" section of this booklet for a complete explanation of allowable charge.

Question

How will my benefits be paid if my Heritage provider recommends that I see a provider who is not part of the Heritage network?

Answer

If you utilize the services of a provider who is not part of the Heritage network, in most cases benefits are paid at the lower, out-of-network benefit level. In addition to higher copayments, you may also be responsible for the difference between the provider's billed amount and Premera Blue Cross's allowed amount.

See the individual benefit descriptions elsewhere in this booklet for more details.

Question

What happens if I need care when I am outside of Washington?

Answer

Your WEA Select Medical Plan provides benefits when you or your covered family members are outside of Washington.

If you are in the State of Alaska, you will receive the in-network level of benefits when you seek services from Alaska providers who have preferred or participating agreements with Premera Blue Cross. Many hospitals and other health care providers have such agreements with us. Refer to our provider directory to find an Alaska preferred or participating provider.

When you are outside Washington or Alaska, benefits are provided through The BlueCard Program.

THE BLUECARD PROGRAM (Out-Of-Area Services)

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

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

Here's How The BlueCard Program Helps Keep Costs Down

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

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

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

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

Here's An Example Of How The BlueCard Program Helps Keep Costs Down

Suppose you receive covered medical services for an illness while you are on vacation or living in another state. You show your identification card to the provider to let him or her know that you are covered by Premera Blue Cross. The provider has negotiated with the Host Blue a price of \$80, even though the provider's standard charge for this service is \$100. The provider bills the Host Blue \$100. The Host Blue forwards the claim to us and indicates that the negotiated price for the covered services is \$80. We then base the amount of the claim that you pay -- your coinsurance percentage -- for the covered services on that \$80 negotiated price, not the \$100 billed charge. So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100).

Please Note: The coinsurance percentages above are for illustration purposes only. The example assumes that your health care program has no copayments and that the deductible has been met. Look in the benefit section of this booklet for your payment responsibilities under this program.

Non-BlueCard Claim Submission

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

BlueCard Worldwide^(R)

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

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

Further Questions?

If you have questions or need additional information about using your identification card outside Washington and Alaska, please call our WEA Select Service Team. To locate a preferred provider in another Blue Cross and/or Blue Shield Licensee service area, call 1-800-810-BLUE (2583) or visit the website at www.bcbs.com/healthtravel/finder.html. Be sure to specify that the suitcase on your ID card has a "PPO" in it and you wish to locate a "preferred provider."

When You Travel

When you travel, your coverage travels with you, anywhere in the world because your WEA Select Blue Cross Plan identification card is recognized by most hospitals and many doctors nationwide.

For more information, please see The BlueCard Program (Out-of-Area Services) on page 19.

Claims For Hospital Benefits

For care covered by hospital inpatient benefits, such as hospitalization, hospital charges for surgery and related diagnostic tests, **Blue Cross/Blue Shield hospitals** will submit claims for you.

However, some hospitals may not submit claims for you. Should this occur, simply fill out a claim form or use the hospital's own claim form. Then, send the form and itemized bills to the Blue Cross Plan servicing the area in which the care was provided. If you need assistance, call the WEA Select Service Team at 1-800-722-1471.

Claims For Surgical-Medical Benefits

If you receive care from a Blue Cross/Blue Shield physician, the physician will normally submit claims for you. Nonparticipating physicians may ask you to submit your own claims; if so, please use a claim form to submit claims for covered services to Premera Blue Cross.

Claims For Other Medical Benefits

Many hospitals and physicians will submit claims for services covered by other medical benefits, such as outpatient diagnostic tests or office visits. In some cases, you must send us the claim form yourself. You should send it to Premera Blue Cross.

Preferred Provider Claims

You may be eligible for increased benefits when you use preferred providers. Normally, preferred hospitals and physicians will submit claims for you.

Outside The United States

To be reimbursed for covered hospital or physician services in hospitals that don't submit claims for you, you must submit a claim form for the overseas services to Premera Blue Cross (the address is on the claim form). The claim must contain a clear statement of the services provided, including all procedures, the diagnosis, and itemized charges.

CARE MANAGEMENT

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important.

This program's benefits do not require preauthorization for coverage. You must be eligible on the dates of service and services must be medically necessary. We encourage you to call the WEA Select Service Team to verify that you meet the required criteria for claims payment and to help us identify admissions which might benefit from case management.

CASE MANAGEMENT

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high cost care to make more efficient use of your program's benefits. The decision to provide benefits for these alternatives is within our sole discretion. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

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

To request additional Case Management information or to make a Case Management referral call 1-800-344-2227 (toll-free).

APPEALS REVIEW

Should you or your provider disagree with a Care Management determination, please refer to the procedures outlined under the "Your Ideas, Questions, Complaints, And Appeals" section (see page 57).

BENEFITS

Specific Benefits - Section I

The following benefits are not subject to your program's General Benefits Reimbursement Formula on page 37, nor are they subject to your program's revolving five-year maximum.

Physician Office And Home Visit Benefit

Your program provides payment for one visit per physician (as defined in the "Definitions" section of this booklet) per day in the physician's office or in the enrollee's home. "Visit" means a personal interview between the enrollee and the physician, including spinal manipulations, and will not include any visit in which the doctor does not see the patient on a personal basis.

Covered services will be paid at 100 percent of allowable charges subject to a \$25 copayment for services rendered by a Heritage provider or a \$30 copayment for services rendered by a Non-Heritage provider.

The office and home visit benefit does not cover the following:

- Any related charges, such as diagnostic X-ray and laboratory services. These charges may be covered under the "General Benefits" section of this benefit booklet.
- Visits made at the time of a surgical procedure, or during that surgery's pre- or post-operative care periods.
- Physician telephone consultations or any other situations where the enrollee is not examined in person.
- Preventive medical care, psychiatric conditions, voluntary second surgical opinion, nonsurgical treatment of morbid obesity, nonsurgical treatment of TMJ, or chemical dependency. These services may be covered under other provisions of your program.

Please see "What Your Program Does Not Cover" on page 46 for additional limitations and exclusions.

Naturopathic Services

Benefits are provided for covered services rendered by a licensed naturopathic physician (N.D.). Benefits will be provided at 100 percent of allowable charges subject to a \$25 copayment for services rendered by a Heritage provider or a \$30 copayment for services rendered by a Non-Heritage provider. Benefits are not provided for hair analysis, non-prescription drugs, or homeopathic or naturopathic remedies, medicines, and devices.

Benefits for acupuncture are described under separate benefit provisions below.

Acupuncture Services

Benefits are provided for acupuncture services up to a maximum of 12 visits per enrollee per calendar year. Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition. Covered services will be paid at 100 percent of allowable charges subject to a \$25 copayment for services rendered by a Heritage provider or a \$30 copayment for services rendered by a Non-Heritage provider.

Preventive Medical Care Benefit

Your program provides preventive medical care up to a maximum benefit of \$200 each calendar year for each enrollee or up to \$500 per enrollee per calendar year from birth through age 3. Covered services rendered by a Heritage provider are paid at 100 percent of allowable charges. Covered services rendered by a Non-Heritage provider are paid at a constant 80 percent of allowable charges.

Examples of covered services are:

- a. Routine physical examinations.
- b. Well-baby examinations (beyond the three-week period specified under "Routine Newborn Care").
- c. Diagnostic laboratory and X-ray services performed in connection with such examinations.
- d. Immunizations.

- e. Approved wellness classes offered by physicians and hospitals.

The majority of providers require you to pay for wellness classes at the time of service. For reimbursement, complete a Subscriber Claim Form and send with the provider's bill to:

Community Wellness
Premera Blue Cross
ATTN: Claims
PO Box 91059
Seattle, WA 98111-9159

For contraceptive services, drugs or devices benefit information, please see the "Contraception Services" benefit on page 40.

Preventive Medical Care benefits **are not** available for:

- a. Services which are related to a specific illness, injury or a definitive set of symptoms exhibited by the enrollee. (These services may be covered under other provisions of your program.)
- b. Vitamins or nutritional supplements.
- c. Services for dental examinations or treatment, or for the fitting of dental appliances or dentures, or other services provided by a licensed dentist or denturist.
- d. Services for eye examinations or the fitting of eyeglasses or contacts.
- e. Services, supplies or procedures in excess of the specified benefit maximum.
- f. Routine fitness testing (such as aerobic capacity, flexibility, body fat percentage, etc.).
- g. Services for a routine mammogram. (These services are covered under the "General Benefits" of your program.)
- h. Well-baby examinations during the first three weeks from birth. (These services are covered under "Routine Newborn Care.")

Please see the "What Your Program Does Not Cover" section (Page 46) for additional limitations and exclusions.

Stop Smoking Benefit

Your program will pay a constant 50 percent of actual charges incurred by a covered enrollee for eligible expenses which directly relate to the enrollee's selected smoking cessation program up to a maximum benefit of \$250 during the enrollee's lifetime. Eligible expenses are limited to those services customarily used in a formal treatment program to assist the enrollee to quit smoking tobacco. Treatment must be performed by a recognized organization, group or individual known to normally and routinely provide such treatment.

For smoking cessation prescription drugs and supplies benefit information, refer to the Prescription Drug benefit on page 24.

Excluded are expenses for over-the-counter drugs and supplies, travel, meals, lodging, books, tapes, and other personal expenses or charges considered to be incidental, unreasonable or inconsistent with the intent of this benefit.

Prescription Drugs

This benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also included in this benefit are injectable supplies (please see "Injectable Supplies" below for more information). For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the enrollee's out-of-pocket expense exceed the cost of the drug or supply.

The pharmacy benefit is a 3-tier program. Drugs fall into one of three categories or "tiers," each with a different copay. Tier 1 consists of generic drugs, Tier 2 of preferred brand-name drugs, and Tier 3 of non-preferred brand drugs. Drugs are designated as "preferred" or "non-preferred" by Premera's Pharmacy

and Therapeutics Committee. This committee is staffed by doctors and pharmacists who use medical studies and research to choose effective and safe drugs for the preferred drug list. For more information, please go to www.premera.com/wea and visit the Pharmacy section in the left-hand column.

Each enrollee must pay a "copay" for each separate new prescription or refill. A "copay" is defined as a fixed up-front dollar amount that you're required to pay the pharmacy for each prescription drug purchase.

Retail Pharmacy Prescriptions

Generic Drugs	\$7 copay
Preferred List Brand Name Drugs	\$20 copay
Non-Preferred List Brand Name Drugs	\$30 copay

Dispensing Limit

Benefits are provided for up to a 34-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

Home Delivery Pharmacy

Generic Drugs	\$10 copay
Preferred List Brand Name Drugs	\$15 copay
Non-Preferred List Brand Name Drugs	\$25 copay

Dispensing Limit

Benefits are provided up to a 100-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

Injectable Supplies

When hypodermic needles and syringes are purchased along with the related injectable prescription medication, only the copay for the injectable prescription medication will apply.

When hypodermic needles and syringes are purchased separately from the related injectable prescription medication, the Preferred List Brand Name Drug copay will apply for each item purchased, providing you have a written prescription from your health care provider for each item.

The Preferred List Brand Name Drug copay will apply to purchases for alcohol swabs, test strips, testing agents and lancets, providing you have a written prescription from your health care provider for each item. A separate copay will apply to each item purchased.

Retail Pharmacy Benefit

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

To avoid paying the retail cost for a covered prescription drug and negating the plan's discounts, be sure to present your identification card to the pharmacist for all prescription drug purchases.

- **Nonparticipating Retail Pharmacies** You pay the full price for the drug(s) and submit a claim for reimbursement. Please see the "How Do I File A Claim" section in this booklet for more information.

After you've paid the required copay, benefits are paid at 60% of the allowable charge for the prescription or refill. You are responsible for the difference between the pharmacy's billed charge and our allowable charge. This benefit applies to all prescriptions filled by a nonparticipating pharmacy, including those filled via mail or other home delivery.

If you need a list of Participating Pharmacies, please call the WEA Select Service Team at 1-800-722-1471. You can also call the toll-free Pharmacy Locator Line; this number is located on the back of your Premera Blue Cross ID card.

Home Delivery Pharmacy Benefit

You can often save time and money by filling your prescriptions through our Home Delivery Pharmacy program. After you've paid any required copays, we'll pay the participating home delivery pharmacy directly. This benefit is limited to our participating home delivery pharmacy. For more information on the home delivery pharmacy program, or to obtain order forms, please contact our Customer Service department.

Please Note: Copays, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don't apply to this benefit. Copays required under this benefit don't apply to other benefits of this plan.

How To Use The Home Delivery Pharmacy Program

Ask your physician to prescribe needed medications for up to the maximum dispensing limit stated earlier in this benefit, plus refills. If you're presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a new prescription or refill to the home delivery pharmacy. Please see the "How Do I File A Claim" section in this booklet for more information.

To obtain additional details about the home delivery pharmacy program, you may call our Pharmacy Benefit Administrator's customer service department at 1-800-626-6080 or visit our Web site at www.premiera.com/wea, click on Pharmacy in the left-hand column, click on MyPharmacyPlus along the top of the page.

What's Covered

This benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs and vitamins (Federal Legend and State Restricted Drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of "Prescription Drug" (please see the "Definitions" section in this booklet).
- Compounded medications of which at least one ingredient is a covered prescription drug.
- Prescriptive oral agents for controlling blood sugar levels.
- Glucagon and allergy emergency kits.
- Prescribed injectable medications for self-administration (such as insulin).
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also included are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Prescription smoking cessation drugs, up to \$250 per member each calendar year.
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms and cervical caps).

Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit), are covered under benefits for medical equipment. See the "General Benefits" benefit.

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

Exclusions

This benefit doesn't cover:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but aren't limited to nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g., infant formulas or protein supplements).

- Growth hormones. Services are covered under other benefits of this program when medically necessary and appropriate.
- Non-prescription contraceptive methods (e.g., jellies, creams, foams or devices).
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss).
- Drugs for experimental or investigative use.
- Biologicals, blood or blood derivatives. Services are covered under other benefits of this program when medically necessary and appropriate.
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order.
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility. Services are covered under other benefits of this program when medically necessary and appropriate.
- Replacement of lost or stolen medication.
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon). Please see the "Infusion Therapy" benefit.
- Drugs to treat infertility, including fertility enhancement medications.

Prescription Drug Volume Discount Program

Premiera Blue Cross participates in a program that provides discounts on the costs of certain prescription drugs used by our enrollees on an annual basis. The total net savings generated by the volume discount program is applied toward future rate calculations and/or settlements, on a pro rata basis, for all group and individual contracts with prescription drug coverage. Your Right To Safe And Effective Pharmacy Services State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call the WEA Select Service Team.

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

Questions And Answers About Your Prescription Drug Benefits

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

Your prescription drug benefit uses a preferred drug list. (This sometimes is referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the preferred list.

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

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

It's important to note that your plan provides benefits for non-preferred brand-name drugs, but at a higher cost to you.

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

2. When can my plan change the preferred drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?

Our Pharmacy and Therapeutics Committee reviews the preferred drug list frequently throughout the year. This committee includes medical practitioners and pharmacists from the community. They review current medical studies and pharmaceutical information to decide which drugs to include on the preferred list.

If you're taking a drug that's changed from preferred to nonpreferred status, we'll notify you before the change. The amount you pay for a drug is based on the drug's designation (as a generic, preferred or nonpreferred drug) on the date it's dispensed. The pharmacy's status as participating or nonparticipating on the date the drug is dispensed is also a factor.

3. What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of your plan's overall benefit design, and can't be changed. Provisions regarding substitution of generic drugs are described above in question #1.

You can appeal any decision you disagree with. Please see the "What If I Have A Question Or An Appeal" section in this booklet, or call the WEA Select Service Team for information on how to initiate an appeal.

4. How much do I have to pay to get a prescription filled?

The amount you pay for covered drugs dispensed by a retail pharmacy or through the home delivery pharmacy benefit is described above.

5. Do I have to use certain pharmacies to pay the least out of my own pocket under this plan?

Yes. You receive the highest level of benefits when you have your prescriptions filled by participating pharmacies. Over 90% of the pharmacies (more than 1,000 individual pharmacies) in Washington are part of our network. Your benefit covers prescription drugs dispensed from a nonparticipating pharmacy, but at a higher out-of-pocket cost to you as explained above.

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

6. How many days' supply of most medications can I get without paying another copay or other repeating charge?

The dispensing limits (or days' supply) for drugs dispensed at retail pharmacies and through the home delivery pharmacy benefit are described in the "Dispensing Limit" provision above.

In certain circumstances, we may limit the amount dispensed based on medical necessity, or to amounts appropriate for a usual course of treatment. In making this determination, we take into consideration accepted pharmacy practice standards, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines and standard reference compendia.

Benefits for refills will be provided only when the member has used three-fourths (75%) of the current supply. The 75% is calculated based on the number of units and days supply dispensed on the last refill.

7. What other pharmacy services does my health plan cover?

This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by a licensed pharmacy. Other services, such as diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Home Health Care Benefit

Your program provides home health care benefits to homebound enrollees for the treatment of a covered medical condition or accidental injury that requires **medically necessary skilled care, subject to a \$50 annual copayment**. For information on Home Health Care and an explanation of medically necessary skilled care versus maintenance/custodial care, please call the WEA Select Service Team at:

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357 **Please Note:** Only calls from the hearing-impaired will be accepted on this line.

To be covered, home health care cannot be maintenance or custodial care. It must meet ALL of these requirements:

- It must provide **skilled** medical care, as described in this section.
- It must be furnished and billed by a covered home health agency, as described in this section under "Covered Home Health Care Services."
- It must be, in the judgment of Premiera Blue Cross, "Medically Necessary" and not maintenance or "Custodial Care" (see the Definitions section).
- It must be included in a Home Health Care plan of treatment.

Note: Benefits may not be provided for every service or supply included in the treatment plan. We may exclude or limit benefits for home health care services unless such services are both skilled medical care and medically necessary.

Skilled medical care means services primarily to treat an illness or accidental injury which can only be furnished by a health care provider with specific medical knowledge and technical training, such as a registered nurse, a physical therapist, a speech therapist, or a respiratory therapist.

Skilled care does not include services that are primarily for ongoing maintenance of the enrollee's health, rather than treatment of an illness or accidental injury, even if furnished by one of the above-named health care providers.

Examples of skilled medical care include:

- Intramuscular or intravenous administration of medication.
- Complex dressing changes.
- Monitoring unstable vital signs.
- Acute respiratory care.
- Physical, occupational, and speech therapy.

Covered Home Health Care Services

When included in your Home Health Care plan of treatment, benefits will be provided at 100 percent of allowable charges for the medically necessary, skilled home health care services described in this section of your booklet. To be covered, home health care services must be furnished and billed by a covered home health agency. A covered home health agency is a provider that is Medicare-certified as a home health agency, or licensed or approved as a home health agency according to the applicable laws of the state in which it operates.

Covered services are:

- Intermittent Skilled Home Care Visits. An intermittent visit is one that uses the reasonable amount of time required to perform a specific skilled medical service.

They must be performed by an employee of the home health agency who is: a registered nurse; a licensed practical nurse; a licensed or registered physical therapist or occupational therapist; a certified respiratory therapist; or a speech therapist certified by the American Speech, Language, and Hearing Association. Benefits are also provided for appropriate services of a Medical Social Worker performing services specified in the treatment plan.

- Intermittent Home Health Aide Services. Home health aide visits are only covered when performed concurrently with skilled care and under the direct supervision of one of the providers listed under "Intermittent Home Care Visits," above. Only intermittent, not continuous, visits are covered.
- Disposable medical supplies and prescription drugs which are prescribed by a physician, and provided and billed by the home health agency.

In addition to exclusions and limitations stated under **"What Your Program Does Not Cover,"** this benefit is not provided for:

- Home care provided on an "around-the-clock," 24-hour, or continuous basis.
- Custodial or maintenance care (see the Definitions section).
- Homemaker or housekeeping services.
- Supportive environmental materials, such as handrails or ramps.
- Services performed by family members or volunteer workers.
- Social services.
- Psychiatric conditions.
- Separate transportation charges.
- Services, supplies, or providers not included in the Home Health Care plan of treatment, or not named as covered.

Hospice Care Benefit

Benefits will be provided at 100 percent of the allowable charge for hospice care for a terminally ill enrollee not to exceed a six-month period, subject to a \$50 annual copayment. Benefits will be available during the last six months of life, as determined by the patient's physician. The initial six-month period begins on the first day of covered hospice care. To be covered, hospice care services must be furnished and billed by a hospice agency that is Medicare-certified as such or state-licensed or state-certified as such by the state in which it operates and must be part of a written plan of care prescribed and periodically reviewed by a physician (M.D. or D.O.). Such physician must certify that the enrollee is terminally ill and that hospital or skilled nursing home confinement would be required in the absence of hospice care. The plan of care shall also describe the services and supplies for the palliative care and medically necessary treatment to be provided to the enrollee. Such plan of care is subject to utilization review performed by us.

This hospice benefit covers only the services and supplies listed below:

- Home care up to a maximum of six months for:
 - Visits by each of the following for intermittent care: a registered or licensed practical nurse; a licensed physical therapist; a certified respiratory therapist; an American Speech and Hearing Association certified speech therapist; a certified occupational therapist; a master of social work; or a home health aide who is directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the medically desired results).
 - Prescription drugs and insulin directly related to treatment of the terminal illness.
 - Medical supplies normally used for hospital inpatients, such as oxygen, catheters, needles, syringes, dressings, materials used in aseptic techniques, irrigation solutions, and intravenous solutions.
 - Rental of durable medical apparatus and medical equipment such as wheelchairs, hospital beds, respirators, splints, trusses, braces, or crutches needed for treatment.
- Up to 10 days of inpatient care in a hospice that is Medicare-certified as such or state-licensed or state-certified as such by the state in which it operates when ordered by the attending physician (M.D. or D.O.).

- Up to 120 hours of respite care for a homebound enrollee in each three-month period of hospice care. The three-month period begins on the initial date of hospice care covered under this program.

In addition to the limitations and exclusions found elsewhere in this benefit booklet, benefits are not available for the following: services provided to other than the terminally ill enrollee, including bereavement counseling; pastoral and spiritual counseling; services performed by family members or volunteer workers; homemaker or housekeeping services, except by home health aides as ordered in the hospice plan of care; supportive environmental materials, such as handrails, ramps, air conditioners and telephones; expenses for the normal necessities of living, such as food, clothing and household supplies; dietary assistance (for example, "Meals on Wheels") or nutritional guidance; separate charges for reports, records, or transportation; legal and financial counseling services; services and supplies not included in the hospice plan of care or not specifically set forth as a covered expense; services and supplies in excess of the specified limitations; services furnished by a hospice that is not Medicare-certified as such or state-licensed or state-certified as such by the state in which it operates.

Skilled Nursing Facility Benefit

A skilled nursing facility is:

- Skilled nursing facility in Washington that is a Heritage Provider;
- Skilled nursing facility in Alaska that is a preferred or participating provider; or
- Medicare-approved skilled nursing facility outside Washington and Alaska that is a preferred ("PPO") provider through the BlueCard Program.

Your program provides benefits for skilled nursing facility care for the treatment of a covered medical condition or accidental injury that requires **medically necessary skilled care, subject to a \$50 annual copayment**. This benefit is only provided when you are at a point where inpatient hospital care is not medically necessary, but skilled care in a skilled nursing facility is. For information on Skilled Nursing Facility Care and an explanation of medically necessary skilled care versus maintenance/custodial care, please call the WEA Select Service Team at:

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357 **Please Note:** Only calls from the hearing-impaired will be accepted on this line.

When the services of a participating skilled nursing facility are not available, please call Care Management for assistance at 1-800-722-1471.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. It must meet ALL of these requirements:

- It must be prescribed by your physician.
- It must be skilled medical care.
- It must be, in our judgment, "medically necessary" and not maintenance or custodial care (see the Definitions section).
- It must be furnished and billed by a participating skilled nursing facility in the service area unless the services are to treat a medical emergency or accidental injury, or a Medicare-approved skilled nursing facility outside the service area.

Note: Benefits may not be provided for every service or supply recommended by your physician. We may exclude or limit benefits for skilled nursing facility services unless such services are both skilled medical care and medically necessary.

Skilled medical care means services primarily to treat an illness or accidental injury which can only be furnished by a health care provider with specific medical knowledge and technical training, such as a registered nurse, a physical therapist, a speech therapist, or a respiratory therapist.

Skilled care does not include services that are primarily for ongoing maintenance of the enrollee's health, rather than treatment of an illness or accidental injury, even if furnished by one of the above-named health care providers.

Examples of skilled medical care include:

- Intramuscular or intravenous administration of medication.
- Complex dressing changes.
- Monitoring unstable vital signs.
- Acute respiratory care.
- Physical, occupational, and speech therapy.

Covered Skilled Nursing Facility Services

When the stated requirements are met, benefits will be provided at 100 percent of allowable charges for covered services provided and billed by a participating skilled nursing facility. Covered services are:

- Room and board accommodations (including the room, meals, and general nursing care).
- Routine laboratory examinations.
- Physical, occupational, speech, and respiratory therapy.
- Medical supplies, prescription drugs, and blood products.

In addition to exclusions and limitations stated under "What Your Program Does Not Cover," this benefit is not provided for:

- Custodial or maintenance care (see the Definitions section).
- Care primarily for senile deterioration, mental deficiency or retardation, psychiatric conditions, or chemical dependency.
- Services or supplies of a personal nature or for the enrollee's convenience, such as: meals for guests; charges for use of radio, television, or telephone; or the services of a barber or beautician.

Voluntary Second Surgical Opinion Benefit

Benefits are available for a second surgical opinion (not subject to the physician home and office visit copayment) which is obtained on a voluntary basis by the enrollee for a covered non-emergency surgical procedure.

The term non-emergency surgical procedure shall mean an elective surgical procedure that may be scheduled at the enrollee's convenience without jeopardizing the enrollee's life or causing serious impairment of the enrollee's bodily functions.

Your program will pay 100 percent of allowable charges for second surgical opinion consultation services, including additional diagnostic tests required as part of the consultation.

To receive proper payment, be sure that you or your physician clearly check the appropriate box on the claim form marked "Second Surgical Opinion."

In addition to the limitations and exclusions found elsewhere in this booklet, this benefit does not include:

- a. Consultation services performed by the operating surgeon.
- b. Diagnostic tests which are not directly related to the condition being treated.
- c. Consultation services when the enrollee is not personally examined by the physician.
- d. Consultation services when the enrollee has already been admitted to the hospital for the surgical procedure.
- e. Benefits for voluntary second surgical opinion consultations specified above are not available for minor surgery that may be performed in the physician's office.

Outpatient Rehabilitative Care And Neurodevelopmental Therapy Benefit

We provide benefits for outpatient rehabilitative services and neurodevelopmental therapy services if all of the following requirements are met:

- You are not confined in a hospital.
- Treatment is part of a formal written treatment program prescribed by a physician.

Outpatient Rehabilitative Therapy

This care restores or improves lost bodily functions caused by injury or illness. It could include speech and hearing therapy, cardiopulmonary rehabilitation, rehabilitative counseling, functional occupational therapy and massage therapy.

Please Note: This benefit does not include physical therapy treatment. Benefits for physical therapy are included under your program's General Benefits. See page 39.

Covered outpatient rehabilitative services from a Heritage provider will be paid at 100 percent of allowable charges after a \$25 copay per visit. Covered services from a Non-Heritage provider will be paid at 100 percent of allowable charges after a \$30 copay per visit. Benefits are provided for up to 45 visits each calendar year if:

- a. Rehabilitative care is given by a licensed or registered therapist;
- b. Rehabilitative care begins within one year of the date the condition began.

Outpatient Neurodevelopmental Therapy

The goal of this therapy is to improve bodily functions related to neurodevelopmental delay or deficiencies. Neurodevelopmental delay or deficiencies are neurological and bodily functions that fail to develop normally after birth. Services may include speech and hearing therapy, physical therapy, massage therapy, rehabilitative counseling and functional occupational therapy.

Your program will provide up to \$30 of allowable charges per day for outpatient neurodevelopmental therapy for up to 45 visits each calendar year.

Neurodevelopmental therapy services are covered for treatment of neurodevelopmental disabilities for enrollees age six or under. The therapy must be medically necessary to restore or improve function, or to maintain function where, in our judgment, significant physical deterioration would occur without these services.

One initial neurodevelopmental evaluation is covered under General Benefits. Additional evaluations will be paid up to the daily benefit dollar maximum of the outpatient neurodevelopmental therapy benefit.

Services must be furnished and billed by a legally operated hospital, by a physician (M.D. or D.O.), or by a physical, occupational, or speech therapist.

Benefits are not provided for:

- a. Neurodevelopmental therapy and related evaluations for enrollees age seven and older.
- b. Nonmedical self-help, such as "Outward Bound" or "Wilderness Survival"; recreational or educational therapy.
- c. Social, cultural, and vocational therapy.
- d. Acupressure.
- e. Services provided by employees of a home health agency or hospice.

Please see "What Your Program Does Not Cover" on page 46 for additional limitations and exclusions.

Audio Benefit

Your program will pay a constant 80 percent to \$500 in allowable charges (up to a maximum payment of \$400) per enrollee in a period of three consecutive calendar years for the following:

- An otologic examination by a physician;
- One audiologic examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation;

- The hearing aid (monaural and binaural) prescribed as a result of such examinations;
- Ear mold(s);
- The hearing aid instrument;
- The initial batteries, cords and other necessary ancillary equipment;
- A warranty;
- Follow-up consultation within 30 days following delivery of the hearing aid;
- In the event that an enrollee elects to return the hearing aid before actual purchase, Premiera Blue Cross will pay 80 percent of allowable rental charges for the use of the instrument for a period of up to, but not to exceed, 30 days; and
- Repair of hearing aid equipment.

You must be examined by a physician within a three-month period prior to obtaining the hearing aid and provide written certification by the examining physician that you are suffering a hearing loss that may be lessened by the use of a hearing aid. Certification and examination requirements will be waived for a covered replacement hearing aid if benefits were provided under this program for the replaced hearing aid.

Exclusions Under The Audio Benefit

In addition to the limitations and exclusions described elsewhere in this booklet, Audio benefits will not be provided for:

- Replacement of a hearing aid for any reason more often than once in a period of three consecutive calendar years.
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid.
- Routine maintenance or alteration of hearing aid equipment.
- A hearing aid which exceeds the specifications prescribed for correction of hearing loss.
- Expenses incurred after your coverage ends under this program unless a hearing aid was ordered prior to that date and was delivered within 45 days after the day your coverage ended.
- Charges in excess of the Audio benefit are not eligible for General Benefits.
- Hearing aids purchased or ordered prior to your effective date of coverage on this program.

Please Note: Submission of claims for the initial hearing aid devices must have the physician certification and your claim for the examination attached.

Nonsurgical Treatment Of Morbid Obesity

Your program will pay a constant 50 percent of allowable charges up to a lifetime maximum of \$750 for nonsurgical treatment of morbid obesity. Eligible expenses are limited to services provided by a physician-supervised (M.D. or D.O.) weight loss program. Related exams and laboratory work are also covered under this benefit.

The enrollee must be morbidly obese with weight gain that constitutes a present or potential threat to life. Morbid obesity is characterized by weight which is at least twice the standard weight for frame size, age, height and sex of the patient, as specified in the current Metropolitan Life Insurance Table.

This benefit will not be provided for:

- Food supplements or replacements.
- Enrollees who are overweight but do not meet the criteria as described for morbid obesity.
- Weight loss programs not supervised by a physician, even when the enrollee's participation in the program is prescribed or recommended by a physician.

Specific Benefits - Section II

The following benefits are not subject to your program's General Benefits Reimbursement Formula on page 37, but they are subject to your program's revolving five-year maximum.

Mental Health Benefit

Inpatient Care

If you **are confined** as a bedpatient in a legally operated hospital, or a state hospital which is operated and maintained by the State of Washington for the care of the mentally ill, Heritage and Non-Heritage provider services and hospital services for mental health conditions, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are covered at a constant 80 percent of allowable charges, subject to the \$150 per enrollee per day, \$450 per enrollee per calendar year maximum hospital inpatient copayment. Services must be consistent with generally recognized standards within a relevant health profession as determined by the Plan. Partial psychiatric hospitalization may be utilized in lieu of inpatient care when deemed medically appropriate by the plan.

General medical benefits may be available for inpatient mental health care if **both of** the following apply:

- The mental health disorder is a documented direct result of an acute head injury or intracranial surgery that necessitated inpatient hospital care.
- Inpatient mental health care must be obtained within 12 months of the head injury or cranial surgery.

Please call the WEA Select Service Team for specific inpatient mental health care benefit information at:

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357 **Please Note:** Only calls from the hearing-impaired will be accepted on this line.

Important: Hospital inpatient services are subject to a \$150 per enrollee per day, \$450 per enrollee per calendar year copayment.

Outpatient Care

If you **are not confined** as a bedpatient in a hospital, medically necessary services for mental health conditions, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition) will be covered as indicated below. Services must be consistent with generally recognized standards within a relevant health profession as determined by the Plan.

- Up to 50 one-hour visits each calendar year for each enrollee. If the provider bills additionally for charges that exceed one hour, each additional hour or portion of an hour will count as an additional visit toward the 50-visit maximum. For example, a single two-hour session will count as two visits.
- A constant 70 percent of allowable charges will be paid for covered services rendered by a Heritage provider.
- A constant 50 percent of allowable charges will be paid for covered services rendered by a Non-Heritage provider.

Services must be provided by a legally operated hospital, or a state hospital which is operated and maintained by the State of Washington for the care of the mentally ill, a licensed physician, a licensed psychologist, or a community mental health agency*. Benefits will also be provided for services rendered by an Advanced Registered Nurse Practitioner (A.R.N.P.), a Licensed Clinical Social Worker (L.C.S.W.), a State-Certified Clinical Social Worker, a State-Certified Mental Health Counselor (C.M.H.C.), any other State-Certified Masters-level mental health provider, or any other provider (see Definitions section) performing services within his or her permitted scope of practice.

*A community mental health agency is a health care provider which is licensed as a community mental health agency by the Washington State Department of Social and Health Services and which has in effect a plan for quality assurance, peer review and supervision by a physician or licensed psychologist.

Mental Health Services And Your Rights

Premera Blue Cross and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations of your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact Premera Blue Cross at one of the following telephone numbers:

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357

Please Note: Only calls from the hearing-impaired will be accepted on this line.

If you would like to know more about your rights under the law, or if you think anything you received from us may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at (360) 236-4010.

Nonsurgical Treatment Of TMJ Dysfunction

Myofascial pain-dysfunction (MPD) is a disorder involving muscles surrounding and adjacent to the temporomandibular joint (TMJ) area which is characterized by: preauricular, temporal, occipital and/or jaw pain; spasm and/or tenderness of the masticatory muscles; and/or limited jaw movement.

Temporomandibular joint (TMJ) dysfunction is a disorder of the temporomandibular joint (the joint which connects the mandible or jawbone to the temporal bone) which is generally characterized by pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat or shoulders; popping or clicking of the jaw; limited jaw movement or locking; malocclusion; overbite or underbite; and/or mastication (chewing) difficulties.

Nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction (MPD) is paid at a constant 50 percent of allowable charges for covered services up to a lifetime maximum benefit of \$1,000 per enrollee. This benefit includes covered services rendered by a Dentist (D.M.D. or D.D.S.).

Benefits for covered hospital and professional services required for the surgical treatment of TMJ dysfunction or MPD are covered at your program's General Benefits Reimbursement Formula.

Limitations: These benefits will not be payable for: dental services and supplies such as crowns, bridgework and dentures; training and educational services; holistic therapy; and orthodontic services, except for splints and guards.

General Benefits - Section III

Revolving Five-Year Maximum

Your program will pay \$5,000,000 per enrollee for covered expenses incurred during any five-consecutive calendar years whether or not there has been an interruption in the continuity of coverage. Benefits paid during the first year are automatically reinstated for use in the sixth year. Similarly, benefits paid during the second year are reinstated in the seventh year . . . those paid in the third year are again available in the eighth year, etc. This revolving reinstatement feature is automatically repeated during each subsequent five consecutive calendar-year period.

If this contract is replaced by a new contract, or if the enrollee becomes covered by another Washington Education Association Select Health Care Plan, any amounts of the maximum which have been used will transfer to the new contract.

General Benefits Reimbursement Formula

Benefit Payment

The general benefits reimbursement formula is the percentage of allowable charges paid by Premiera Blue Cross. The percentage that each enrollee is responsible for is called coinsurance.

When covered services are rendered by a Heritage Provider, your program will provide benefits at 80 percent of allowable charges.

When covered services are rendered by a Non-Heritage Provider, your program will provide benefits at 60 percent of allowable charges.

After the plan pays \$5,500 in benefits for covered services per enrollee (combined for Heritage and Non-Heritage providers), benefits will be paid at 100% of the allowable charge for the remainder of that calendar year.

Benefits paid at constant percentages do not accrue toward the coinsurance maximum.

Covered Services

Your General Benefits cover:

- **Daily hospital service** in a legally operated hospital, including room and board, related ancillary services, and use of an intensive, coronary or constant care unit. Charges for radio, television, long-distance telephone calls, meals for guests and personal comfort items are not covered.

Important: Hospital inpatient services are subject to a \$150 per enrollee per day, \$450 per enrollee per calendar year copayment.

- **Services from a hospital emergency room** are subject to a \$75 copayment per visit. This copayment will be required for each visit to the hospital emergency room, unless the patient is directly admitted to that hospital as an inpatient.
- **Treatment received in the outpatient department of a legally operated hospital**, including scheduled "one day" surgeries, X-ray and radium therapy or chemotherapy.

Please Note: Outpatient surgery services are subject to a \$100 copayment.

- **Surgical and medical care by a physician** (see Definitions section), except as stated in the "Physician Home And Office Benefit."

When multiple or bilateral procedures are performed during the same operative session, by one or more surgeons, benefits will be provided based on the allowable charge for the first or major procedure and one half of the allowable charge for the secondary procedure. In order for benefits to be provided for the secondary procedure(s), it must **not** be listed in the Physician's Current Procedure Terminology (CPT) as a separate procedure or part of a comprehensive code.

Surgical treatment of organic impotence. Benefits are provided only for the **initial** corrective surgical treatment of organic impotence as a result of an illness or an accidental injury. Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures or injuries. Impotence resulting from psychiatric conditions is not covered.

Benefits for a penile prosthesis will be provided when implantation is performed in relation to clinically identified organic impotence resulting from the following conditions:

- a. Accidental injury to the:
 - spinal cord resulting in paraplegia or quadriplegia;
 - pelvic nerves which are inoperable and result in loss of sensation and function.
- b. Post-Surgical:
 - carcinoma of the lower urinary tract, or removal of the bladder or prostate;
 - removal of the rectum;
 - genital system resulting from amputation of the penis or testicles;

- Peyronie's disease;
 - aortic surgery.
- c. Disease
- debilitating neurological disease;
 - the effects of radiation therapy for the treatment of cancer will be reviewed by Medical Review to determine the medical necessity and appropriateness of the proposed treatment of implant surgery.

Benefits are not payable for:

- additional implant surgeries as a result of an unsuccessful procedure or for replacement of a prosthesis, due to defects, injury, or technological advancement with the prosthesis are not covered.
 - sexual counseling relating to impotency or implantation surgery remains an ineligible service. When the cause of impotence is primarily psychological in nature, no benefits will be provided for implantation of a penile prosthesis.
- **Mastectomy And Breast Reconstruction Services** are provided for mastectomy necessary due to illness or accidental injury. For any enrollee electing breast reconstruction in connection with a mastectomy, this benefit covers:
 - Reconstruction of the breast on which mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses; and
 - Physical complications of all stages of mastectomy, including lymphedemas;
 Services are to be provided in a manner determined in consultation with the attending physician and the patient.

- **Dental services for treatment of a fractured jaw or accidental injury to functionally sound natural teeth** if treatment is received within 12 months of the accident. This benefit includes the services of a licensed Dentist (D.M.D. or D.D.S.) or dentist. This benefit will not be provided for injuries caused by biting or chewing. "Functionally sound natural teeth" means the effected teeth are living, natural teeth that are free from decay and do not, at the time of the injury, have extensive restoration, veneer, crowns or splints; periodontal disease or other condition that would cause the teeth to be in a weakened state prior to the injury.

This program also will cover hospital or ambulatory surgical center care for dental procedures, and general anesthesia and related facility services that are medically necessary. This benefit is limited to one the following two reasons:

- The enrollee is under age 7 or is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office;
- The enrollee has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a hospital or ambulatory surgical center.

Please note: This program will not cover the dentist's services unless the service is covered treatment for a dental injury as described above.

- **Private duty acute nursing** services of a registered nurse, in the home, provided such services are medically necessary and are ordered by a physician, up to a maximum benefit of \$5,000 for each enrollee each calendar year. As an alternative to acute nursing services, please refer to page 29 for Home Health Care Benefits.
- **Anesthesia and its administration.**
- **Diagnostic X-ray and laboratory services.**
- **Diagnostic and screening mammography services.**
- **X-ray, radium and radioactive isotope therapy.**
- **Chemotherapeutic agents** or other professionally administered injections of covered medications.

- **Prosthetics and Orthotics*** such as:

- Artificial limbs or eyes;
- Casts;
- Splints;
- Trusses;
- Braces;
- Diabetic testing supplies such as test strips for blood glucose monitors, visual reading and urine test strips and syringes;
- Therapeutic shoes or orthotics for the feet (shoe inserts), including those that are medically necessary to prevent complications associated with chronic peripheral vascular disease. Impression casting for shoe inserts is also provided for covered inserts. Therapeutic shoes or inserts are limited to one pair per calendar year for all conditions combined.
- Following cataract surgery either intraocular lens(es) or contact lens(es), to replace a missing portion of the eye (condition of aphakia), but not both. This benefit is not available for contact lenses only to correct visual acuity.

- Rental or, at our option, **purchase of home medical equipment***, such as:

- Wheelchair;
- Traction equipment;
- Ventilators;
- Hospital-type bed;
- Intermittent Positive Pressure Breathing Apparatus;
- Crutches;
- Dialysis equipment.
- Diabetic equipment such as blood glucose monitor, insulin pumps, and accessories to pumps, and insulin infusion devices.

*Home medical equipment is equipment which can stand repeated use (with the exception of certain consumable medical supplies), and is used in the direct treatment of a covered illness or injury. It is generally not useful to a person in the absence of illness or injury, and is ordered and/or prescribed by a physician.

Benefits are not provided for non-medical equipment or services. Examples are environmental or building modifications, exercise equipment, whirlpool baths, air purifiers or personal convenience or comfort items. Also excluded are transport-related services or supplies such as wheelchair lifts or vehicle modifications.

- **Health Education**

Medically necessary outpatient self-management training and education for a covered condition is covered. Benefits include medical nutritional therapy for diabetes, including services of a dietician or nutritionist or other provider with expertise in diabetes.

- **Physical therapy treatment** by a physician or a licensed/registered therapist in the state where the services are rendered.
- **Licensed ambulance service** to the nearest facility (in Washington state the enrollee may be transported to the nearest preferred facility) equipped to treat the condition. This method of transportation will be covered only when other means would endanger your health and safety. This benefit is not available for private automobiles or taxi services nor is it available for the convenience of either the patient or the family.
- **Blood transfusions**, including the cost of blood and blood derivatives.
- **Dietary formula** which is medically necessary for the treatment of phenylketonuria (PKU), not to exceed an order for five cases in any calendar month. If more than five cases are required for use in any calendar month, benefits will be provided for the additional amount of formula medically necessary to treat the enrollee.

- **Contraception Services**

Your program provides benefits for the contraception services, drugs, and supplies stated below on the same basis as any other covered care.

Prescription Drugs and Devices for Contraception

Oral contraceptives (including emergency contraception) and prescription barrier devices such as diaphragms and cervical caps dispensed by a licensed pharmacy are covered on the same basis as other covered prescription drugs. See the benefit for Prescription Drugs found elsewhere in this booklet for important information regarding pharmacy benefits.

Contraceptive Surgeries, Implants and Injections

Surgical sterilization and implantable contraceptives (including hormonal implants) are covered on the same basis as any other surgery. Injectable contraceptives and associated professional services are covered on the same basis as for therapeutic injections.

Professional Consultations

Office visits and consultations related to contraception are covered as any other professional office visit.

Benefits are not provided for nonprescription contraceptive drugs, supplies or devices; reversal of sterilization; or services, drugs or supplies for fertility enhancement.

- **Obstetrical Care**

Pregnancy, childbirth, and voluntary termination of pregnancy are covered on the same basis as any other condition for all covered enrollees. Obstetrical care benefits include:

- a. Hospital Care

- Inpatient, outpatient and emergency room services, including inpatient post-delivery hospital care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. **Please Note:** Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

- b. Professional Care

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus.
 - Delivery, including cesarean section.
 - Postpartum care consistent with accepted medical practice which is ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife, or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a single fee for childbirth that includes prenatal and postpartum services, this plan will cover that fee as it would any other surgery.

- **Newborn Care**

Newborn children are covered automatically for the first three weeks from birth when the mother is eligible to receive obstetrical care benefits under this program.

The enrollment guidelines outlined in "Who Is Covered And When" will need to be followed in the following situations:

- The mother is not eligible for obstetrical care benefits under this program and the Subscriber wishes to add coverage for the newborn, or,
 - The Subscriber wishes to add coverage for the newborn child beyond the three week period.

When the child meets the coverage requirements outlined above, the regular benefits of this program will apply. Services must be consistent with accepted medical practice and ordered by the attending practitioner in consultation with the mother. Benefits are subject to the child's own copayment and coinsurance requirements. Some examples of covered services include:

a. Hospital Care

- Hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury. **Please Note:** Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

b. Professional Care:

- Inpatient newborn care.
- Follow-up care consistent with accepted medical practice which is ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision for up to 6 months following birth.

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

• **Home Infusion Therapy**

Professional services, supplies, drugs and solutions furnished and billed by one of the following providers:

- a. A home health agency that is Medicare-certified as such or licensed or certified as such by the state in which it operates.
- b. An intravenous therapy provider that is state-licensed or state-certified as both a home health agency and a pharmacy.

In addition to the exclusions and limitations found under "What Your Program Does Not Cover," we will not provide this benefit for:

- Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions.
- Over-the-counter drugs, solutions, and nutritional supplements.
- Drugs and solutions received while you are an inpatient.

• **Treatment Of Chemical Dependency**

Chemical dependency is an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. For the purpose of chemical dependency treatment, benefits for "medically necessary" services will be determined in accordance with the current edition of the Patient Placement Criteria for the of Treatment of Substance Abuse-Related Disorders, as published by the American Society of Addiction Medicine.

An approved treatment facility is a facility approved in the State of Washington pursuant to RCW 70.96A.020(2) or RCW 69.54.030, in the State of Alaska pursuant to Chapter 47.37 AS, or an approved facility in any other state in accordance with the licensing or certification requirements in the jurisdiction where services are rendered which provides an organized program of treatment for chemical dependency.

Benefits for medically necessary covered services including drugs, such as methadone, received by the enrollee and rendered by a state-approved treatment facility or treatment program for the treatment of chemical dependency will be provided subject to the inpatient hospital copayment up to a maximum benefit of \$11,285 per enrollee during any 24-consecutive-month period.

Benefits for medically necessary covered therapeutic and supporting services provided to enrolled family members to assist in the patient's diagnosis and treatment will be subject to the benefit maximum(s) of the patient undergoing treatment for chemical dependency.

Benefits for covered services of a state-approved treatment facility or treatment program will be limited to allowable charges only when we have significant statistical data for a specific service or supply, as determined by the criteria set forth in the definition of allowable charge.

Chemical dependency benefits **will not** be provided for:

- a. Voluntary support groups such as Alanon, Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous;
- b. Separate charges for transportation, records and reports;
- c. Court-ordered services; services related to deferred prosecution, deferred sentencing or suspended sentencing; or services related to motor vehicle driving rights unless deemed medically necessary by Premera Blue Cross.
- d. Please see "What Your Program Does Not Cover" on page 46 for additional limitations and exclusions.

Treatment for detoxification services will be paid as any other medical condition and do not apply towards the Chemical Dependency benefit limit stated above.

- **Inpatient Rehabilitative Care**

This care restores or improves lost bodily functions caused by injury or illness. It could include physical therapy, massage therapy, speech and hearing therapy, rehabilitative counseling and functional occupational therapy.

Benefits are provided up to 120 days each calendar year for inpatient rehabilitative care, subject to the inpatient hospital copayment, when furnished and billed by a legally operated hospital subject to your program's applicable General Benefits Reimbursement Formula.

Benefits begin on the day after your treatment becomes primarily rehabilitative. Benefits are provided when treatment is:

- a. Part of a continuous inpatient stay following acute treatment. Admissions solely for rehabilitative care are not included for benefits;
- b. For services that are necessary to restore or improve lost functions due to illness or injury;
- c. Given in a legally operated hospital with a specialized rehabilitative care department approved by Premera Blue Cross (a list of approved facilities is available from Premera Blue Cross office);
- d. Part of a formal written program of treatment prescribed by a physician; and
- e. Part of a program requiring a variety of rehabilitative services.

These benefits continue as long as you are eligible under this program and need the services of a team of rehabilitative professionals, including a physical therapist, massage practitioner, occupational therapist, speech therapist or a rehabilitation counselor, and as long as these services can only be provided in a hospital, up to a maximum of 120 days each calendar year. Outpatient rehabilitative care benefits are described under Specific Benefits on page 33.

- **Inpatient Neurodevelopmental Therapy**

Inpatient neurodevelopmental therapy services will be furnished to enrollees age six or under. Benefits are provided up to 120 days each calendar year for inpatient neurodevelopmental therapy, subject to the inpatient hospital copayment, when furnished and billed by a legally operated hospital subject to your program's applicable General Benefits Reimbursement Formula. The services must meet all of the following requirements:

- a. The therapy must be medically necessary to restore or improve function, or to maintain function where, in our judgment, significant physical deterioration would occur without the services.
- b. The services cannot be rendered in a lesser care facility.

- c. The therapy is appropriate to the condition being treated.
- d. The treatment is part of a formal written program of treatment prescribed by a physician.

These benefits continue as long as the enrollee is eligible under this program and needs the services of a team of neurodevelopmental professionals, including a physical therapist, occupational therapist, massage practitioner, speech therapist or a rehabilitation counselor, up to a maximum of 120 days each calendar year. Outpatient neurodevelopmental therapy benefits are described under Specific Benefits on page 33.

In addition to the exclusions and limitations found under "What Your Program Does Not Cover" on page 46, we do not provide this benefit for:

- Convalescent care when the need for definitive medical treatment no longer exists or when an inpatient level of care is no longer medically necessary.
- Neurodevelopmental therapy and related evaluations for enrollees age seven and older.

- **Psychological and Neuropsychological Testing**

Benefits are provided up to a maximum benefit of 12 hours per enrollee each calendar year for all services combined. Covered services include testing related to mental health, rehabilitation and neurodevelopmental therapy, and evaluations, including interpretation, necessary to prescribe an appropriate treatment plan. This includes later re-evaluations to make sure the treatment is achieving the desired medical results.

- **Transplants**

Benefits for organ, bone marrow and stem cell transplants are ONLY provided when the transplant is done in a transplant center that has a contract with Premera Blue Cross or is in the special network of transplant centers around the country. ("Transplant center" means the team of physicians that performs the transplant and the hospital in which it is done.)

Benefits are limited to a \$250,000 lifetime maximum, subject to the inpatient hospital copayment and will only be provided when the transplant meets our criteria for benefits.

Premera Blue Cross reserves the right to base payment of transplant benefits on all of the following:

- a. The type of transplant must not be experimental or investigative, based on criteria stated in the definition of "Experimental/Investigative." The type of transplants that currently meet our criteria for coverage are heart, heart/double lung, liver, kidney, pancreas, certain autologous and allogeneic bone marrow transplants, including hematopoietic stem cell harvesting and infusion, whether harvested from bone marrow, peripheral blood, or any other source.

Please Note: For the purpose of this program, the term "transplant" does not include corneal transplants, skin grafts, or the transplant of blood or blood derivatives (except for hematopoietic stem cells). Benefits for such services may be provided under this program's other benefits.

- b. The medical condition must meet Premera Blue Cross established criteria;
- c. The transplant center must qualify under Premera Blue Cross written standards.

Transplant benefits are limited as follows:

The recipient of the transplant must be continuously covered under a WEA Select medical program for at least 12 consecutive months before transplant benefits are payable unless:

1. The transplant is directly related to an accidental injury which occurs on or after the date the recipient became covered under this program; OR
2. The transplant is directly related to a congenital anomaly of a dependent child who has been continuously covered under this program since birth; OR
3. An entire plan is eliminated or the entire group transfers to a WEA medical plan. In such cases, employees **may** be eligible to have the time immediately preceding enrollment on a WEA Plan, credited toward the required 12-month organ transplant waiting period. Please contact Premera Blue Cross for further details.
4. The transplant waiting period has been modified.

- a. If all plans offered in a school district (non-WEA medical plans and WEA Select medical plans) agree to waive the 12-month waiting period and a common lifetime benefit maximum is established for all plans offered in the school district, coverage under the WEA Select plan will be provided in accordance with that agreement.

OR

- b. Enrollees who had coverage before enrolling in a WEA Select medical plan, the maximum allowed for transplant-related services during the first 12 months will be the lesser of:
 - the transplant dollar maximum under the enrollee's prior plan, if any (no coverage if no prior plan benefits); or
 - the transplant dollar maximum under the elected WEA Select Medical Plan.

At the end of the 12-month waiting period, enrollees will be eligible for the transplant benefit maximums of the WEA Select Medical Plan.

Program benefits, limitations, exclusions and preauthorization requirements for recipient and donor costs will be subject to the transplant benefits of the WEA Select Medical Plan. Additionally, all services related to an organ transplant that is determined by Premiera Blue Cross to be experimental and/or investigative or that occurs during the first 12 months the member is enrolled will not be covered. This includes such services as hospitalization, chemotherapy and drugs.

If the recipient is confined in a facility and receiving transplant-related services and supplies on the date the waiting period ends, benefits for covered transplant-related services and supplies will not be provided until after discharge from the facility or from any other facility to which the recipient is transferred.

Transplant Services and Supplies

This benefit covers the following services and supplies for covered transplants as outlined below:

- a. Recipient Costs: Inpatient hospital and professional services and supplies furnished by the transplant center during the inpatient stay in which the transplant is performed. For bone marrow transplants, covered services include any chemotherapy and radiation therapy that is part of the inpatient care that is covered by this benefit.
- b. Donor Costs: We cover the evaluation of the donor organ or bone marrow, its removal, and transport of both the surgical/harvesting team and donor organ or bone marrow. Inpatient hospital and professional benefits described in this program will be provided for an organ or bone marrow donor, beginning on the day of surgery and continuing for up to 10 additional, consecutive days while the donor remains hospitalized. Also covered are bone marrow testing and typing of the brothers, sisters, parents, and children of the enrollee who needs the transplant. Testing and typing of any other potential donor is only covered when the potential donor meets specific medical criteria as determined by Premiera Blue Cross.

In addition to the exclusions and limitations found under "What Your Program Does Not Cover," we will not provide this benefit for:

- Donor costs if the donor is an enrollee, but the recipient is not. However, complications and unforeseen effects from an enrollee's organ or bone marrow donation will be covered as any other illness to the extent not covered under the recipient's coverage.
- Donor costs for which benefits are available under other group coverage.
- Organ or bone marrow search or selection costs (including registry charges), except as named under "Donor Costs" above.
- Nonhuman or mechanical organs, unless we determine they are not experimental or investigative according to the criteria stated under "Definitions."
- Services or supplies that will be paid for by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Services or supplies furnished in connection with or related to a noncovered organ or bone marrow transplant, including follow-up care and any direct complications, consequences, or aftereffects arising therefrom (except as specified at the end of the transplant waiting period for an otherwise covered organ or bone marrow transplant).

- Transportation, except as named under "Donor Costs" above and medically necessary ambulance services as specified under "General Benefits" on page 39.
- Meals and lodging.
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed. Take-home prescription drugs are covered under your Prescription Drug Benefit.

ADDITIONAL INFORMATION

WHAT YOUR PROGRAM DOES NOT COVER (Exclusions And Limitations)

Exclusions

Your program **does not** cover any services or supplies furnished in connection with the following conditions, services or supplies:

1. Services, supplies and procedures related to altering the refractive character of the cornea, and their direct results, including but not limited to, radial keratotomy, corneal modulation, keratomileusis, or refractive keratoplasty.
2. Any services or supplies for which no charge is made, or would not have been made if this program were not in effect, or for charges for services or supplies for which you are not legally liable.
3. Services, supplies or drugs for the treatment of caffeine dependency or abuse.
4. Military and War Related Conditions, Including Illegal Acts
This includes:
 - Acts of war, declared or undeclared, including acts of armed invasion.
 - Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto.
 - An enrollee's commission of an act of riot or insurrection.
 - An enrollee's commission of a felony or act of terrorism.
5. Services or supplies not medically necessary, even if ordered by a court of law, for treatment of a disease, injury, illness or pregnancy.
6. Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage or adoption. Examples of such providers are your spouse, parent, or child.
7. Any service or supply which Premera Blue Cross determines is experimental or investigative on the date it is furnished. Our determination is based on the criteria stated in the definition of "Experimental/Investigative."

If we determine that a service is experimental or investigative, and therefore not covered, you may appeal our decision. We will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.
8. Services, supplies or procedures of complications which Premera Blue Cross determines is experimental or investigative on the date it is furnished. Our determination is based on the criteria stated in the definition of "Experimental/Investigative."
9. Services, supplies or drugs for sex transformations.
10. Milieu therapy (treatment intended primarily to provide a change in environment or a controlled environment).
11. Hair prostheses, such as wigs or hair weaves, transplants, and implants. Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth.

Limitations

Your program does not cover the following, **except** as specifically stated:

1. Services, supplies and procedures for cosmetic, plastic or reconstructive purposes and their complications are not covered benefits, except:
 - a. To repair a defect caused by an accidental injury if the services, supplies and procedures are rendered within 12 months of the accident.
 - b. To treat functional disorders.
 - c. Reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit.
 - d. To repair a dependent child's congenital anomaly. (See Definitions)

Limitations . . . continued

Below are some examples of services that are not covered:

- a. Upper or lower jaw augmentation or reduction procedures (orthognathic surgery), unless the criteria previously stated in this limitation is met.
 - b. Surgery for sagging skin of the eyelids (blepharochalasis) unless to treat a functional disorder.
 - c. Surgery for sagging skin of the face, neck, abdomen, hips or extremities (meloplasty, rhytidectomy or lipectomy).
 - d. Breast enlargement, reduction or uplift procedures, except as specified.
 - e. Reshaping of the nose (rhinoplasty).
2. Eye refractions, eyeglasses, contact lenses, except as specifically stated or the fitting of eyeglasses to correct vision.
 3. Services or supplies for learning disabilities, except therapy services as stated under the Neurodevelopmental Therapy Benefit on pages 33 and 42.
 4. Vocational counseling; outreach; job training; and other counseling or training services, except as stated under "Health Education" on page 39, and "Treatment Of Chemical Dependency" on page 41.
 5. Services or supplies received in and billed by a nonparticipating hospital owned or operated by a county, state or federal agency, except:
 - a. For treatment of a medical emergency.
 - b. As otherwise required by state or federal law.

All services and supplies must be furnished and billed by the hospital.

6. Any services provided by an institution which is primarily a rest home, a home for the aged, a nursing home, or a convalescent home or any of like character, except as specifically covered by your program.
7. Custodial care. This includes room, board, any other facility services, and professional care provided for senile dementia, mental deficiency or retardation, or is primarily to assist you with activities of daily living because of your physical or mental condition, or age. See page 60.
8. Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient facilities, or unless your medical condition makes inpatient care medically necessary.
9. Transportation services and devices, except as stated under the "Transplants Benefit", "Donor Costs" on page 44 and medically necessary ambulance services as specified under "General Benefits" on page 39.
10. Routine physical and marital examinations, including screening examinations, tests, X-rays, laboratory, pathological services and machine diagnostic tests, other than routine mammography screening, unless related to a specific illness, injury, pregnancy or a definitive set of symptoms or as specified in the "Preventive Medical Care Benefit" on page 23.
11. Routine foot care procedures such as, but not limited to, the trimming of nails, corns or calluses, or routine hygienic care; services and supplies for fallen arches or other symptomatic complaints of the feet; impression casting for prosthetics and appliances (therapeutic shoes or inserts), including prescriptions therefor except as specifically provided in the "Home Medical Equipment, Prosthetic and Orthotic Benefit" on page 39.
12. Hearing examinations; hearing aid, new or replacement, except as specified in the "Audio Benefit" on page 33.
13. Hospital care for the extraction of teeth or other dental procedures, except as stated on page 38.
14. Services of a licensed dentist (D.M.D. or D.D.S.) or denturist except as specified on page 38; dental services such as extractions, prostheses, orthodontia, crowns, fillings and treatment of gingivitis. Benefits will not be provided for injuries caused by biting or chewing. Also excluded are dental implants to replace missing teeth, except as part of medically necessary treatment of a dental injury as described on page 38.
15. Services or supplies for nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain-dysfunction (MPD), except as specified on page 36.

Limitations . . . continued

16. Inpatient and outpatient rehabilitative care (including, but not limited to, speech, physical, massage, and occupational therapy), except as specified under the "Inpatient Rehabilitative Care Benefit" on page 42 or the "Outpatient Rehabilitative Care Benefit" on page 33. Benefits also will not be provided for care which, during a period of continuous hospitalization, develops primarily into rehabilitative care, except as specifically provided by your program.
17. Inpatient and outpatient neurodevelopmental therapy, except as specified under the "Inpatient Neurodevelopmental Therapy Benefit" on page 42 or the "Outpatient Neurodevelopmental Therapy Benefit" on page 33.
18. Transplants, except as specified on page 43.
19. Treatment for alcohol or drug use, abuse or dependency, except as specifically defined under the definition of chemical dependency and as provided by the "Treatment of Chemical Dependency Benefit" on page 41.
20. Services, supplies, drugs and procedures for reproductive and sexual disorders and defects, whether or not the consequence of illness, disease or injury, including, but not limited to: impotence (except as specified), frigidity, infertility, reversal of surgical sterilization, artificial insemination and in-vitro fertilization.
21. Well-baby care, including physical examinations, except as specifically provided under the "Preventive Medical Care Benefit" on page 23 and under the "Newborn Care Benefit" on page 40.
22. Any services or supplies not specifically listed as covered benefits; any expenses for professional nursing care, except as specified on page 38.
23. Treatment of psychiatric conditions, including treatment of eating disorders, (such as anorexia nervosa, bulimia, or any similar conditions), except as specified on page 35.
24. Services and supplies for which the enrollee is entitled to receive benefits from any federal, state or governmental program, excluding Medicare, except as otherwise required by law.

Effect of Medicare: If the employer is subject to federal "working aged" laws, this program provides benefits primary over Medicare for covered, active employees or their covered spouses, who are 65 or older and have elected primary coverage under this program.

This program also provides benefits primary over Medicare, to the extent that an employer-sponsored health care program is required to do so by federal law, for enrollees who are entitled to Medicare because of a kidney transplant or renal dialysis, and for covered active employees or their dependents when the employee or dependent is under age 65, disabled, and covered by Medicare.

25. Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering:
 - Motor vehicle medical, motor vehicle no-fault, or personal injury protection (PIP) coverage; or,
 - Commercial premises or homeowner's medical premises coverage, or other similar type of contract or insurance.
26. Drugs and medicines, except for drugs and medicines delivered by and administered while you are confined in a medical facility, or prescription drugs covered under the "Retail Pharmacy Drug Benefit," the "Home Delivery Pharmacy Program," the "Home Health Care Benefit" and "Hospice Care Benefit," the "Chemical Dependency Treatment Benefit," or the "PKU Dietary Formula Benefit." Even if prescribed by a physician, this program does not cover: fertility drugs, regardless of their intended use; over-the-counter drugs, supplies; food supplements; herbal, naturopathic, or homeopathic medicines or devices; and vitamins that don't require a prescription.
27. Home health care except as specified on page 29.
28. Hospice care except as specified on page 30.
29. Smoking cessation or treatment of tobacco dependency or abuse, except as specified in the Prescription Drug Benefit and on page 24.
30. Nonsurgical treatment, including drug therapy, of obesity and morbid obesity, except as specified on page 34. We do not provide benefits for the surgical treatment of obesity, including morbid obesity, or for any complications directly caused by such surgery. However, if benefits were provided under this program for a surgery for treatment of obesity, including morbid obesity, performed between October 1, 1986, and September 30, 1990, then benefits will be provided for covered services required to treat complications caused by that surgery.

Limitations . . . continued

31. Services and supplies obtained from providers outside the United States will be covered on the same basis as those same services and supplies obtained in this country. However, they must not be, in our determination, experimental or investigative according to the criteria stated in the definition of "Experimental/Investigative."

Coordination Of Benefits (COB)

You may also be covered under one or more other group programs. This program includes a "coordination of benefits" feature to handle such situations. We will coordinate the benefits of this program with those of your other programs to make certain that, in each calendar year, the total payments from all programs are not more than the total allowable expenses. All of the benefits of this program are subject to coordination of benefits.

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

Definitions

- **Program** means all of the following, even if they do not have their own coordination provisions:
 - Group or blanket disability insurance or health care programs issued by insurers, health care services contractors and health maintenance organizations;
 - Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans;
 - Government programs which provide benefits for their own civilian employees or their dependents.
 - Group coverage required or provided by any statute, including but not limited to Medicare and Workers' Compensation.
 - Group student coverage which is sponsored by a school or other educational institution, and which includes medical benefits for illness or disease.

Each contract or other arrangement for coverage described above is a separate program. Also, if an arrangement has two or more parts and the coordination of benefits provision applies only to one of the two, each of the two parts is a separate program.

- **Allowable Expense** means the usual, customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the programs involved. When a program provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Claim Determination Period** means a calendar year.

Effect On Benefits

An important part of coordinating benefits is determining the order in which the programs provide benefits. One program is responsible for providing benefits first. This is called the "primary" program. The primary program provides its full benefits as if there were no other programs involved. The other programs then become "secondary." This means they reduce their payment amounts so that the total benefits from all programs are not more than the allowable expenses. Coordination of benefits always considers amounts that would be payable under the other program, whether or not a claim has actually been filed.

Here is the order in which the programs should provide benefits:

First: A program that does not provide for coordination of benefits.

Next: A program which covers an enrollee as other than a dependent.

Next: A program which covers an enrollee as a dependent. For dependent children, the following rules apply:

When the Parents Are Not Separated or Divorced: The program of the parent whose birthday falls earlier in a year will be primary, if that is in accord with the coordination of benefits provision of both programs. Otherwise, the rule set forth in the program which does not have this provision shall determine the order of benefits.

When the Parents Are Separated or Divorced: If a court decree makes one parent responsible for paying the child's health care costs, that parent's program will be primary. Otherwise, the program of the parent with custody will be primary, followed by the program of the spouse of the parent with custody, followed by the program of the parent who does not have custody.

If the rules above do not apply, the program that has covered an enrollee for the longest time will be primary, except that benefits of a program which covers an enrollee as a laid-off or retired employee, or as the dependent of such an employee shall be determined after the benefits of any program which covers an enrollee as other than a laid-off or retired employee, or as the dependent of such an employee. This applies, however, only when other programs involved have this provision regarding laid-off or retired employees.

If none of the rules above determine the order of benefits, the program that has covered the employee or subscriber for the longest time will be primary.

Any amount by which a secondary program's benefits have been reduced in accord with this section shall be used by the secondary program to pay the enrollee's allowable expenses not otherwise paid. However, the enrollee must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary program determines its obligation to pay for allowable expenses based on all claims that were submitted up to that time during the claim determination period.

Supplemental Coordination Of Benefits

When an enrollee is covered under more than one WEA Select Medical Plan (Plans 1, 2, 3, 4 and/or Foundation), the following provisions will apply:

1. Any required enrollee cost sharing (including deductibles, coinsurance and/or copayments) is waived.
2. Instead of the stated percentages, benefits are provided at 100 percent of allowable charges for covered services, drugs or supplies.
3. Benefit dollar maximums are doubled up to the allowable charge for covered services and supplies. Benefits with visit maximums are not doubled.

In the event a service or supply is excluded on one plan but covered on the other plan, benefits will be provided at 100% of allowable charges up to the benefit maximum (if any) for the plan which covers the service or supply.

Benefits will be provided in accordance with the regular Coordination of Benefits provisions described earlier if it would result in a higher benefit payment.

GENERAL PROVISIONS

Rights To Benefits After Termination

Benefits are not provided for services, treatment, medical attention or care which an enrollee received after his or her termination of coverage or the termination of this contract.

No rights are vested under this program.

Third Party Liability (Subrogation)

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we may be entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party," because it is a party other than you or us. "Subrogation" means that we may collect directly from that third party to the extent we have paid on your behalf for illness or injury caused by the third party. Because we have paid for your illness or injuries, we may be entitled to recover for those expenses.

To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. In recovering benefits provided, we may at our election either hire our own attorney or be represented by your attorney. If we choose to be represented by your attorney, we will pay, on a contingent basis, a reasonable portion of the attorney fees which are necessary for asserting our right of recovery in the case. This portion will usually not be more than 20 percent of the amount we seek to recover. We will not pay for any legal/attorney costs incurred by or on your behalf, and you will not be required to pay any portion of the legal/attorney costs incurred by or on our behalf.

Prior to accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. You must also cooperate with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery.

To the maximum extent permitted by law, we are "subrogated" to your rights against any third party who is responsible for the condition, meaning that we have the right to sue any such third party in your name, and have a secured interest in, and lien upon, any recovery to the extent of the amount of benefits paid by us and for our expenses in obtaining a recovery. We may also assert our right to recover benefits directly from the third party.

Uninsured and Underinsured Motorist Coverage

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

The amount of reimbursement that we are entitled to receive under this provision is the amount in excess of the amount you receive from all insurance sources which fully compensate you for all damages arising from the accidental injury for which such benefits have been paid.

Certification Of Need For Health Care Services

We have the right to require proof of medical necessity from an enrollee receiving benefits under this program. This proof may be submitted by you or on your behalf by providers. No benefits will be available under this program if the proof is not provided or acceptable to us.

Notice Of Information Use And Disclosure

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

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

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

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

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

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

With reasonable notice, you may view your medical records at your provider's office, and receive a copy of your records by paying for copying. To make these requests, contact your provider's office.

Transfer Of Benefits:

Assignment, Garnishment And Attachment

All benefits are personal and available only to enrollees. They will not be provided for anyone else.

The right to payment under Premera Blue Cross's contract with the WEA is not subject to attachment or garnishment, and Premera Blue Cross will not honor any assignment of it to anyone. In paying for services, Premera Blue Cross may, at its option, make the payment to the enrollee, the participating employer group, the provider, another carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such remittance shall discharge Premera Blue Cross to the extent of the amount remitted so that it shall not be liable to anyone aggrieved by its choice of payee.

Right Of Recovery

This Plan will have the right, upon demand, to recover overpayments or payments obtained through fraud, error, mistake, or payments made in excess of the maximum amount necessary to satisfy the intent of the Coordination of Benefits provision (refer to the "Additional Information" section of this booklet), made to: the enrollee; the provider; other insurers; any service plans; any other organization, or on behalf of an enrollee; or someone who is not eligible to receive benefits.

If reimbursement is not made, such overpayments or payments will be deducted from future payments.

Fraudulent Claims

If the enrollee claims benefits for which no care, service or supply is received, the claim will be denied.

Venue

All suits or legal proceedings brought against Premera Blue Cross by you or anyone claiming any right under this program must be filed:

- Within three years of the date we denied in writing the rights claimed under this program, or of the completion date of the independent review process, if applicable; and
- In the State of Washington or the state in which you reside or are employed.

All suits or legal proceedings brought by us will be filed within the appropriate statutory period of limitation. In all suits or legal proceedings brought by us venue may lie, at our option, in King County, State of Washington.

Notice Of Other Coverage

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

- Any legal action or claim against another party for a condition or injury for which we paid benefits; and the name and address of that party's insurance carrier.
- The name and address of any insurance carrier providing personal injury protection (PIP), underinsured motorist, uninsured motorist, or any other insurance under which you are or may be entitled to recover compensation.
- The name of any other group insurance plan(s) under which you are covered.

HOW TO SUBMIT A CLAIM

With Premera Blue Cross health care coverage, you have fewer claims to submit than you would under most health care programs. That's because Heritage providers bill us directly when Premera Blue Cross is your primary carrier. However, if you are outside of Washington and Alaska and have received medical services from a hospital or other health care provider, your provider of care must bill the local Blue Cross and/or Blue Shield Plan directly. If your provider does not bill the local Plan for you, you will have to submit the bill yourself. If you need assistance, please call the WEA Select Service Team at 1-800-722-1471.

When you receive services from a provider in Washington or Alaska that does not have an agreement with us, or from a provider outside Washington and Alaska for vision services, you will need to submit these claims to us. You must submit your claim on a Subscriber Claim Form along with the itemized bill. Subscriber Claim Forms are available at the nearest Premera Blue Cross office. Follow these simple steps:

- Name of the subscriber (from identification card);
- Name of the patient;
- Subscriber identification number (from identification card);
- Group number (from identification card);
- Name, address and IRS tax number of the provider;
- Information about other insurance coverage;
- Diagnosis or ICD-9 code;
- Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English nomenclature for each service.
- Date of service;
- Itemized charges for the services rendered; and
- If the services rendered are for the treatment of an accident, the date, time, location and a brief description of the accident.

A separate Subscriber Claim Form is necessary for each patient and each provider. When filling out the form be sure to complete all required information, sign the form in the space provided, and attach an itemized bill from your provider. Bills received from you or your provider will not be considered to be claims until all the necessary information is included.

If the claim is for a Second Surgical Opinion, please mark the appropriate box on the Subscriber Claim Form.

Timely Filing Of Claims

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date on which expenses were incurred for any other services or supplies; or
- For enrollees who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater.

We will not provide benefits for claims we receive after the later of these two dates, nor will we provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline.

Hospital Service

For hospital services, present your Premera Blue Cross identification card to the admitting clerk when you are admitted to or receive outpatient services from a Heritage hospital. The hospital will bill us and we will send you an Explanation of Benefits form that shows the amount charged and the amount we paid to the hospital. If you are admitted to or receive outpatient services from a hospital not affiliated with Premera Blue Cross (Non-Heritage Hospital) and the hospital does not bill for you, you must submit the itemized bill to us along with a Subscriber Claim Form. Payment will be made directly to you.

Physicians' And Other Providers' Services

Heritage Providers

If you receive services from a Heritage provider, present your Premera Blue Cross identification card to the provider. The provider will bill us directly. When we send payment for covered services to that provider, we will send you an Explanation of Benefits form.

Heritage providers will seek payment solely from Premera Blue Cross for the provision of covered services, and accept such payment as full and final payment for such services. Heritage providers may seek payment from the enrollee only for the following:

- Services not covered by this program;
- Copayments; and
- Amounts in excess of stated benefit maximums.

Non-Heritage Providers

If you receive services from a provider that has not contracted with us and the Subscriber Claim Form indicates that full payment has been made, payment for covered services will be made directly to you. Payment usually will be made to the provider or jointly to you and the provider as copayees when there is no indication that the bill has been fully paid.

Be sure your group and subscriber identification numbers are shown on all bills or correspondence. The numbers are listed on your identification card.

For information on out-of-area providers, please see "The BlueCard Program (Out-of-Area Services)" on page 19.

Send Your Claims To:

Premera Blue Cross
P.O. Box 91080
Seattle, Washington 98111-9159

YOUR IDEAS, QUESTIONS, COMPLAINTS, AND APPEALS

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

When You Have Ideas

We would like to hear from you on ways we can continue to improve our service. If you have an idea, suggestion, or opinion, please let us know. You can call us at the numbers listed below or send your ideas and comments to:

**Premera Blue Cross
Customer Assessment Manager
P. O. Box 327
Seattle, WA 98111-0327**

When You Have Questions

Call your provider of care when you have questions about the health care services you receive. Please call the WEA Select Service Team with any other questions regarding your Premera Blue Cross program.

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357

When You Have A Complaint

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

When you have a complaint, call or write the WEA Select Service Team. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We will let you know when we have received your written complaint. We may also request more information when needed. When we receive all needed information, we will review your complaint and notify you of the outcome and the reason for it as soon as possible, but in no case more than 30 calendar days.

When You Have An Appeal

An **appeal** is an oral or written request that we reconsider 1) our decision on a complaint, or 2) our decision to deny, modify, reduce, or end payment, coverage, or authorization of coverage. This includes admissions to, and continued stays in, a facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you are appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

You have the right to give us comments, documents, or other information to support your appeal.

Although we will accept an appeal made by phone to our WEA Select Service Team, it is preferable to put appeals in writing. Please send all written appeals to the address shown below. We will let you know when we receive your appeal.

You may mail appeals to:

**Premera Blue Cross
Appeal Coordinator
P.O. Box 91102
Seattle, Washington 98111-9202**

Appeals Process

Our standard appeal process has two levels of review:

Level I: The Level I Appeal panel will decide most appeals within 30 calendar days. This panel will include health care providers who were not involved in the initial decision. We can extend our review time up to 15 more calendar days if we need more information. You will be notified if a delay occurs.

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

- **A decision to change, reduce, or end an ongoing service**

We will mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than 30 calendar days from the day we receive your appeal, unless you agree to a longer one.

- **Denial of an experimental or investigative service**

We will mail you a response within 20 calendar days from the date we receive your appeal. The 20-day period may be extended with your informed written consent.

- **Urgent appeals (See "Urgent Appeals" below)**

If you do not agree with the decision reached in the Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. **You must make your request for a Level II review no more than 60 calendar days after the date you receive our Level I decision.**

Level II: Your appeal will be reviewed by a Premiera Blue Cross panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. Unless your appeal is deemed urgent (see "Urgent Appeals" below), the panel will evaluate all the information within 45 calendar days of the date we receive your Level II request.

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

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

Notice Unless your appeal is deemed urgent, we will mail you a written notice of our Level I and Level II decisions within 5 calendar days after the review is complete.

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

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

Please call the WEA Select Service Team if you have questions or need more information about our complaint or appeal process. The numbers are shown in "When You Have Questions" above.

WEA Claim Appeal

If you do not agree with a claim denial made by Premera Blue Cross, you may submit a further appeal to the Washington Education Association. The claim may be appealed by the enrollee to the WEA Board or its appointed Benefit Services Advisory Board. The Board or Benefit Services Advisory Board shall conduct a hearing at which the participant shall be entitled to present his or her opinion, and any evidence in support thereof. Thereafter, the Board or Benefit Services Advisory Board shall issue a written decision affirming, modifying or setting aside the former action. For more information on the WEA claim review, you may contact Aon Consulting at (206) 467-4646.

The Board of Directors or its appointed Benefit Services Advisory Board of the Washington Education Association has the authority under this contract to reconsider claims for benefits which have been denied in whole or in part by Premera Blue Cross and to determine if additional benefits should be provided. This provision will provide a means whereby a claim for benefits can be reconsidered and additional benefits provided to the extent herein specified and to the extent there are WEA funds available to cover such additional benefits. The circumstances under which the appointed Benefit Services Advisory Board may approve additional benefits when a claim for benefits is denied are outlined in the WEA "Procedure for Benefit Services Claim Review."

It is further understood that (i) costs incurred in connection with a claims appeal such as attorneys fees, travel expenses and so forth are not covered, (ii) that the Board of Directors or its appointed Benefit Services Advisory Board cannot have access to medical information without the written permission of the subscriber, and (iii) the decisions made under this provision do not establish precedents.

ADDITIONAL INFORMATION ABOUT YOUR COVERAGE

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

You may also obtain a brochure which includes the following information:

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

If you would like to receive this information, please go to our Web site, shown below. If you do not have access to the Web, please call the WEA Select Service Team. The phone numbers are shown in "When You Have Questions" in this booklet.

Our Web address is: <http://www.premera.com/wea>

DEFINITIONS

These terms are used in this benefit booklet:

Allowable Charge

The allowable charge shall mean one of the following:

- **Providers In Washington and Alaska Who Have Agreements With Us**

For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You will be responsible only for any applicable deductibles, copayments, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this program.

Your liability for any applicable deductibles, coinsurance, copayments, and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

- **Providers Outside Washington and Alaska Who Have Agreements With Other Blue Cross Blue Shield Licensees**

The allowable charge is determined as stated in "The BlueCard Program" on page 19.

- **Providers Who Do Not Have Agreements With Us Or Another Blue Cross Blue Shield Licensee**

Except as set forth below, the allowable charge will be no greater than the maximum allowance we otherwise would have allowed had the medically necessary covered services been furnished by a provider that has an agreement in effect with us.

When you seek services from providers that do **not** have agreements with us, your liability is for any amount above the allowable charge, and for any coinsurance, copayments, amounts in excess of stated benefit maximums, and charges for noncovered services.

We reserve the right to determine the amount allowed for any given service or supply.

Ancillary Services

Services such as special rooms, supplies, drugs, dressings and laboratory tests you may receive when you are in the hospital or a skilled nursing facility.

Assistant Surgeon

The service of an assistant physician when required by regulation or medical necessity.

Congenital Anomaly

A marked difference, from the normal structure of a body part, that is evident at birth. Abnormal physiologic developmental conditions such as dental implants or breast reconstruction outside of the mandated reconstruction benefits for breast cancer would not be covered.

Constant Reimbursement Percentage

A reimbursement percentage which remains unchanged and has no variation.

Custodial Care

Any portion of a service, procedure, or supply which, in our judgment, is provided primarily:

- For ongoing maintenance of the enrollee's health and not for its therapeutic value in the treatment of an illness or accidental injury.
- To assist the enrollee in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over administration of medication not requiring constant attention of trained medical personnel.

Effective Date

The date on which the enrollee's coverage starts under this program. This date is established by, and appears on the records of, Premiera Blue Cross. If an enrollee's coverage lapses and is reinstated, the enrollee's reinstatement date will be the effective date.

Enrollee

The subscriber or any eligible dependent enrolled for coverage under this program.

Exclusion

A provision that states Premera Blue Cross has no obligation under this program to provide any benefits.

Experimental/Investigative Services

Experimental or investigative services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply which meets one or more of the following criteria as determined by us:

- A drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- Reliable evidence does not demonstrate the safety and efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management, or treatment.
- The service is the subject of ongoing clinical trials or other continuing scientific research to determine its maximum tolerated dose, toxicity, safety, or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.
- Evaluation of reliable evidence indicates that the service does not show a demonstrable benefit for a particular disease or condition.

Reliable evidence includes, but is not limited to, reports and articles published in authoritative medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

The documentation used to establish our criteria will be made available for your examination at our office, if you send us a written request.

Health Care Facility

Any legally operated hospital, skilled nursing facility, approved treatment facility, which are defined elsewhere in this section. These are also referred to as "facilities."

Health Care Provider

Any physician or other covered provider of service or facility that treats or provides a service to patients; also called "provider."

Hospital

- Legally Operated Hospital
 - Is licensed; and
 - For compensation from its patients and on an inpatient basis is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or ill persons by or under the supervision of a staff of physicians, and continuously provides 24-hour-a-day nursing service by or under the supervision of registered nurses; or
 - Is any other licensed institution with which the Plan has an agreement to render hospital services.

The following are not considered hospitals: residential treatment facilities; skilled nursing facilities; nursing homes; convalescent homes; custodial homes; health resorts; hospices; places for rest; places for the aged; places solely for the treatment of drug abuse and/or alcoholism; and places for the treatment of pulmonary tuberculosis.

Please Note: Services and supplies provided by a hospital owned or operated by a county, state or federal agency are not covered, except for services furnished and billed by a hospital for a medical emergency or as otherwise required by state or federal law.

Injury

Physical harm or disability sustained by the enrollee which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. The injury must have occurred at an identifiable time and place. Injuries do not include illness or infection, except infection of a cut or wound resulting from an accident.

Inpatient

A hospital-registered inpatient for whom the hospital makes a daily room charge.

Medical Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Examples of a medical emergency are severe pain, suspected heart attacks, and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medically Necessary

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

- Essential to the diagnosis or the treatment of an illness, accidental injury, or condition harmful or threatening to the enrollee's life or health, unless provided for preventive services when specified as covered under this program.
- Appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature.
- Medically effective treatment of the diagnosis as demonstrated by:
 - sufficient evidence exists to draw conclusions about the effect of the health intervention on health outcome;
 - evidence demonstrates that the health intervention can be expected to produce its intended effects on health outcomes;
 - expected beneficial effects of the health intervention on health outcomes outweighs its expected harmful effects.
- Cost effective as determined by being the least costly of the alternative supplies or levels of service which is medically effective and can safely be provided to the enrollee. A health intervention is cost effective if there is no other available health intervention that offers a clinically appropriate benefit at a lower cost.
- Not primarily for research or data accumulation.
- Not primarily for the convenience of the enrollee, the enrollee's family, the enrollee's physician, or another provider.

Health Intervention is defined as an activity undertaken for the primary purpose of preventing, improving or stabilizing a medical condition. Activities that are primarily custodial, part of normal existence, or undertaken for the convenience of a patient, family, health professional or third party are not health interventions.

Health Outcome is defined as the results of medical interventions that directly affect the length or quality of life of the enrollee.

Sufficient Evidence is defined as evidence derived from clinical research that is (1) peer-reviewed, (2) well-controlled, (3) directly or indirectly relates to intervention to health outcomes, and (4) reproducible both within and outside of a research setting.

Mental Health Conditions

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

Orthodontia

That branch of dentistry which deals with the development, prevention and correction of irregularities of the teeth and bite (malocclusion). Malocclusion is the abnormal position and contact of the upper and lower teeth which may affect chewing or cause facial, jaw and/or joint pain.

Physical Therapy

Treatment of an illness, injury or condition by physical means, such as massage, hydrotherapy, heat or similar modalities, when performed by a licensed or registered therapist.

Physician

One of the following who is licensed to provide medical services in the state where they were received:

- Doctor of Medicine and Surgery (M.D.).
- Doctor of Osteopathy and Surgery (D.O.).

In addition, professional services will be covered under this contract, but only when the provider is: providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this contract, and, providing a service for which benefits would be payable if the service were provided by a physician as defined above.

Provider

A licensed or certified individual regulated under Title 18 or Chapter 70.127 RCW to practice health care services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045, and only to the extent services are covered under this contract.

Provider also includes certain health care facilities and other providers of health care services and supplies as stated in this contract. Health care facilities owned or operated by government entities are included as required by state and federal law.

Please Note: Benefits for some types of services furnished by the provider categories included in the definition of "provider" listed above may be limited or excluded under this program. For further details, please refer to the appropriate sections of this plan booklet or call the WEA Select Service Team at:

Toll-Free: 1-800-722-1471

Hearing-impaired TDD: 1-800-842-5357 **Please Note:** Only calls from the hearing-impaired will be accepted on this line.

Subscriber

The employee who is eligible for the benefits of this medical care program. The employee and dependents eligible for coverage are also referred to as "enrollees."

Subscription Charges

The monthly rates established by us as consideration for the benefits offered in this contract.

**LIFE AND ACCIDENTAL DEATH
AND DISMEMBERMENT**



**Life Insurance Underwritten by:
Provident Life and Accident Insurance Company**

CERTIFICATE PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

Chattanooga, Tennessee
(herein called the Provident)

Certifies that it has issued Group Policy No. W-138 (herein called the Plan) to

WASHINGTON EDUCATION ASSOCIATION

(herein called the Policyholder)

The Plan provides the benefits described on the following pages for certain Employees covered under the Plan. This booklet gives the principal provisions of the Plan. The Plan alone constitutes the entire contract between the Provident and the Policyholder.

Employees become covered under the Plan as provided on a following page. This booklet becomes the Employee's certificate of coverage while covered under the Plan.

The benefits and provisions described on the following pages are subject in all respects to the terms and conditions of the Plan.

SECTION I - SCHEDULE OF BENEFITS

PLAN 2

Description

Plan 2 shall apply to any eligible Employee covered under the Plan and who is covered under the Policyholder's WEA Select Medical Plan of benefits provided by the Policyholder.

BENEFITS FOR EMPLOYEES

Life Insurance -

Payable to beneficiary in the event of death from any
cause See Schedule Below

Schedule of Life Insurance

Actual Attained Age	Benefit Amount
Less than 35	\$20,000
35 to 39	\$16,400
40 to 44	\$14,000
45 to 49	\$12,000
50 to 54	\$10,400
55 to 59	\$ 9,200
60 to 64	\$ 6,800
65 to 69	\$ 4,600
70 to 74	\$ 3,000
75 to 79	\$ 2,600
80 And Over	\$ 2,000

Actual attained age at the time of death will be used with respect to any death benefits payable.

Any change in amount of insurance due to attaining an age will become effective on the first day of the month following the anniversary of the Employee's date of birth.

Accidental Death and Dismemberment Insurance -

The Principal Sum is payable for loss of life or loss of more than one member. One-half the Principal Sum is payable for loss of one member.

Principal Sum See Schedule Below

Schedule of AD&D (Principal Sum)

Actual Attained Age	Amount of Principal Sum
Less than 35	\$20,000
35 to 39	\$16,400
40 to 44	\$14,000
45 to 49	\$12,000
50 to 54	\$10,400
55 to 59	\$ 9,200
60 to 64	\$ 6,800
65 to 69	\$ 4,600
70 to 74	\$ 3,000
75 to 79	\$ 2,600
80 and Over	\$ 2,000

Actual attained age at the time of death will be used with respect to any death benefits payable. Such actual attained age on the date you actually suffer the loss will be used with respect to any dismemberment benefits payable.

Any change in the amount of Principal Sum due to attaining age will become effective on the first day of the month following the anniversary of the Employee's date of birth.

SECTION II - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

Coverage For You

You are eligible if you are covered as a subscriber on the WEA Select Medical Plan - Premera Blue Cross.

You are in the eligible class if you are:

- Actively at Work on the basis normally required for your occupation as an Employee of an employer qualified under the Plan as a Participating Employer Group; and
- enrolled under the Washington Education Select Health Plan or Select HealthPlus.

Participating Employer Group means the WASHINGTON EDUCATION ASSOCIATION and its affiliates, and any division of a Washington Public School District which has elected to participate under the Plan.

Exclusion: If you are (1) an honorary member, or (2) a student member, you are not eligible for coverage under this Plan.

Your coverage begins on the first of the month following the date of enrollment provided payment is remitted for you on a monthly basis.

The effective date of the Plan described on the following pages is October 1, 1993.

If you are in an eligible class, you will be covered on the date your coverage becomes effective under the Washington Education Association Select Health Plan or Select HealthPlus; provided you have completed:

- a full day of Active Work on that date; or
- a full day of Active Work on your last regularly scheduled work day and are able to work on the date you become eligible.

If you do not meet the requirements of (a) and (b) above, the coverage will become effective on the date you return to Active Work.

EXCEPTION: The Active Work or Actively at Work requirement will not apply to you if you are on summer vacation or if it is not a regularly scheduled work day (weekend or holiday), on your Eligibility Date; however, if you, because of disability, are confined to your home or a legally operated public or private hospital on such date, your insurance will not become effective until the day following the date you cease to be so confined.

Active Work and Actively at Work mean performing your regular duties for a full work day for your Employer.

When Coverage Ends

Your coverage will cease on the earliest of:

- a. the date the Plan ceases;
- b. the date the Plan ceases for the class of Employees to which you belong;
- c. the last day of the calendar month following the calendar month during which you are no longer a member of the class eligible, except as provided below;
- d. the date ending the period for which your last contribution is made, if you are required to pay a part of the cost of the Plan; or
- e. the last day of the calendar month following the calendar month during which your active employment ceases; or
- f. the date an approved leave of absence or sabbatical expires and you have not returned to your former active employment.

EXCEPTION: If you cease to be in an eligible class because of termination of employment, or reduction in number of hours (to less than the number required to be eligible for the Policyholder's Select Health Plan or Select HealthPlus), your coverage will be continued in force until the later of (1) the maximum months allowable under COBRA or other mandated extension, provided you have elected such continuation under the Policyholder's Select Health Plan or Select HealthPlus, or (2) the end of the following month, unless your coverage terminates earlier as described above.

Continuation of Coverage For You if the Coverage Ceases

If your Active Work ends as the result of a strike, lockout or labor dispute, arrangements may be made to continue your coverage under the Plan for a period not to exceed 6 months. Your coverage ceases when Active Work ends unless arrangements are made to continue the coverage within the time allowed. You should inquire of your employer regarding arrangements for continuation of your coverage during a strike, lockout or labor dispute.

Coverage may be continued under this provision or under any provisions requiring the Policyholder to offer continuation of coverage under any federal law. Coverage may not be continued under both provisions.

SECTION III - COVERAGE PROVISIONS

Life Insurance For You

Benefit Provision

The amount of life insurance is shown in the Schedule of Benefits. The Provident will pay the amount shown to your beneficiary if you die from any cause while insured.

Payment will be made as soon as proof of death is received.

Beneficiary

You may name anyone as your beneficiary. You must file the name or names at the office of the Policyholder on a form approved by the Provident.

You may change your beneficiary at any time by giving notice in writing. The effective date of the change is the date the request is signed. However, the Provident is not liable for any amount paid before the request is received.

If you name more than one beneficiary, they will share equally unless you provide otherwise.

If a beneficiary dies before you, his or her share will be paid equally to the surviving beneficiaries, unless you state otherwise. Any amount for which a beneficiary is not named will be paid to the surviving person or persons in the first of the following classes of successive preference beneficiaries: Your (a) spouse; (b) children, including legally adopted children; (c) parents; (d) brothers and sisters; (e) executor or administrator.

In determining such person or persons, we may rely upon an affidavit by a member of any of the classes of preference beneficiaries. Payment based upon such affidavit will be full acquittance unless, before such payment is made, we have received at our Home Office written notice of a valid claim by some other person. If two or more persons become entitled to benefits as preference beneficiaries, they will share equally.

Any benefits for loss of life payable to a minor may be paid to the legally appointed guardian of the minor, or if there be no such guardian, to such adult or adults as have in our opinion assumed the custody and principal support of such minor.

Assignment

You may assign all rights and interests in and to those benefits which are payable on account of your death. The assignment shall not be made to, nor be for the benefit of, the Policyholder.

The owner's rights and those of any beneficiary will be subject to the assignment on and after the date it is received by us at our Home Office. We are not responsible for the adequacy of any assignment.

Optional Modes of Settlement

You may elect to have the death benefit paid under any one of the optional modes of payment offered by the Provident. The election must be made by you in writing to the Provident Home office. After your death, the beneficiary has this same right.

Benefit Provision

1. If you become Terminally Ill while insured under the Life Insurance provision or while your death benefit is being continued under Insurance During Disability Before Age 65, you may apply for this Living Benefit Option. This election is allowed only once in your lifetime and is subject to the conditions shown below.
2. Terminally Ill means you are expected to die within 6 months. This must be certified by a Physician and accepted by Provident.

Proof

Living Benefits will be payable when Provident receives acceptable proof from your Physician that you are Terminally Ill. Such proof must be in a form that is satisfactory to Provident. At the time such proof is given, Provident may have you examined by a Physician of Provident's choice. This will be at Provident's expense.

Coverage

The amount of the Living Benefit will be:

- a. 50% of the Life Insurance amount shown in the Schedule of Benefits, if that amount is at least \$10,000;
- b. determined as of the date Provident accepts proof that you are Terminally Ill;
- c. payable only if you are living when payment is made; and
- d. not more than \$100,000.

In no event will the amount payable to your beneficiary upon your death, plus the amount payable to you for this Living Benefit, exceed the amount that would have been payable to your beneficiary if you had not applied for this Living Benefit.

The amount available for you to convert to a personal policy under the Conversion of Life Insurance provision will be reduced by the amount of the Living Benefit paid to you.

3. Waiver of Premium

We will waive such premium that becomes due following payment of the Living Benefit. Such waiver of premium will be subject to all paragraphs in the Insurance During Disability Before Age 65 provision; except the first sentence of the first paragraph shall not apply.

Exclusions

Living Benefits will not be payable if:

- a. your Life Insurance amount is less than \$10,000;
- b. you have assigned your Life Insurance benefits;
- c. Provident has been notified that all or a portion of your Life Insurance is to be paid to your former spouse as part of a divorce agreement; or
- d. you become Terminally Ill as a result of:
 1. an attempted suicide; or
 2. injuring yourself on purpose.

Insurance During Disability Before Age 65

If you become disabled before age 65, and while insured, the insurance will continue as long as you are disabled without further payment of premium. To be considered disabled, you must be unable to do the material and substantial duties of any work for which you are or become fitted by reason of education, training or experience.

You must provide proof of disability acceptable to the Provident. The first proof must be given within 12 months after the disability begins. Proof must be provided once each year as required by us.

The extension of coverage shall **on approval** become effective on the later of (1) the date of commencement of such disability or (2) the date for which premium payment for the employee is discontinued.

Exception Proof of disability will not be submitted until your Select Medical/Life coverage has terminated. A proof of disability made at the end of your coverage will be subject to your age at the time total disability commenced, not your age at the time the application is made.

Any reductions in the amount of insurance as provided in the Schedule of Benefits will apply to any insurance being continued under this provision.

If you die during approved disability, the amount of insurance then in effect will be paid to your beneficiary. Proof must be furnished within one year after death that you were disabled until the date of death.

The provision "Insurance During Disability Before Age 65" will cease on the earliest of: (1) the date you cease to be totally and continuously disabled or fail to furnish satisfactory proof of disability as required by the Provident, (2) the date you attain your 70th birthday, (3) the date the Life Insurance benefit is terminated as a result of amendment of the Plan, (4) the date the Life Insurance benefit is terminated with respect to your Participating Employer Group, or (5) the date the Plan is terminated.

If a converted policy is issued under the Plan, it must be returned without claim before insurance will be continued under this provision. Any premiums paid for the converted policy will be returned to you.

If you die prior to the time you have to furnish proof, any amount of insurance paid under this provision will be reduced by the amount of the converted policy.

However, if the converted policy is returned without claim, the amount of the policy will be paid to your beneficiary as a benefit under the Plan. All premiums paid under the converted policy will also be paid to your beneficiary.

The Provident may, at Provident's expense, have you examined by a physician of our choice.

If proof of your disability is not accepted by the Provident, any legal suit must be brought within 3 years after proof is not accepted.

Conversion of Life Insurance

If The Life Insurance For You Ceases While The Life Insurance Plan Continues -

If all or any part of your life insurance ceases because your employment ends, you may convert to an individual policy. Converted insurance may be of any type of the level premium whole life plans then in use by UNUM. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The policy will not contain disability or supplementary benefits.

You must apply for the policy within 31 days after your life insurance ceases. Proof of good health is not required.

The premium for the policy will be based on your:

- a. age;
- b. class of risk; and
- c. form and amount of policy.

If your life insurance ceases because you are no longer a member of the class eligible, you must convert it on the same basis as above.

If the Life Insurance Plan Ceases -

If your life insurance has been in effect for at least 3 years, and

1. the Plan ends, or
2. the Plan ceases to include your class of Employees.

you may convert to an individual policy on the same basis as above. The converted policy will be limited to \$3,000.00.

If your life insurance is being continued because of disability and you recover or fail to give any required proof of disability, your life insurance may be converted. To do so you must apply within 31 days from the date of recovery or from the date proof was required.

The converted policy will become effective at the end of the 31-day period allowed for conversion. If you die during that period, the amount of life insurance you could have converted will be paid to your beneficiary. Nothing will be paid under this provision if any amount is paid under the provision "Insurance During Disability Before Age 65".

If you are not given written notice of your Conversion Privilege at least 15 days before the end of the 31-day conversion period, it will be extended to the earlier of (1) 25 days after the date notice is given, or (2) 91 days after your Group/Term Life Insurance coverage ends. Written notice may be presented to you or mailed to your last known address.

Accidental Death and Dismemberment Insurance For You

Benefit Provision

The Provident will pay a benefit for loss due to accidental injury as shown in the table below. The loss must occur within 365 days after the date of the accident. You must be covered under the Plan on the date of the accident.

The benefit is called the Principal Sum, and it is shown in the Schedule of Benefits.

The benefit for loss of life will be paid to your beneficiary. All other benefits will be paid to you.

Table of Losses

Loss of Life	The Principal Sum
Loss of More than One Member	The Principal Sum
Loss of One Member	One-Half The Principal Sum
Maximum-All Losses-Any One Accident	The Principal Sum

Loss of a member shall mean the:

1. loss of a hand by total severance at or above the wrist;
2. loss of a foot by total severance at or above the ankle joint; or
3. total loss of the sight of an eye.

Beneficiary

You may name anyone as your beneficiary. You must file the name or names at the office of the Policyholder on a form approved by the Provident.

You may change your beneficiary at any time by giving notice in writing. The effective date of the change is the date the request is signed. However, the Provident is not liable for any amount paid before the request is received.

If you name more than one beneficiary, they will share equally unless you state otherwise.

If a beneficiary dies before you, his or her share will be paid equally to the surviving beneficiaries, unless you state otherwise. Any amount for which a beneficiary is not named will be paid to the surviving person or persons in the first of the following classes of successive preference beneficiaries: Your (a) spouse; (b) children, including legally adopted children; (c) parents; (d) brothers and sisters; (e) executor or administrator.

In determining such person or persons, we may rely upon an affidavit by a member of any of the classes of preference beneficiaries. Payment based upon such affidavit will be full acquittance unless, before such payment is made, we have received at our Home Office written notice of a valid claim by some other person. If two or more persons become entitled to benefits as preference beneficiaries, they will share equally.

Any benefits for loss of life payable to a minor may be paid to the legally appointed guardian of the minor, or if there be no such guardian, to such adult or adults as have in our opinion assumed the custody and principal support of such minor.

Limitations and Exclusions

Benefits are not paid for losses caused directly or wholly by:

- a. bodily or mental infirmity;
- b. ptomaines;
- c. bacterial infections, except those which occur with and through a cut or wound at the time of the accident;
- d. any other kind of disease;
- e. hernia in any form;

- f. medical or surgical treatment (except surgical treatment required by the accident and performed within 365 days after the accident);
- g. war or any act of war;
- h. suicide or self-inflicted injury, whether sane or not; or
- i. the commission of an assault or felony by you.

Claim Payments

Does Not Apply to Life Insurance - Notice of Claim

Written notice of claim must be given within 20 days after loss, or as soon as possible. The notice must be given to the Provident, an authorized agent, or the Policyholder, with information identifying you.

Claim Forms

When a notice of claim is received, the Provident will provide claim forms for the filing of proofs of loss. If such forms are not sent within 15 days, you will have met the proof of loss requirement if you give the Provident a written statement of the nature and extent of the loss within the time fixed in this Plan.

Proofs of Loss

Written proof must be given to the Provident within 365 days after the date of loss. However, a claim will still be considered if it was not possible to furnish proof within this time and the proof was furnished as soon as possible. Except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than 2 years after the date the expense was incurred.

Time of Payment of Claims

All benefits provided by the Plan will be paid upon receipt of proof of loss.

Payment of Claims

Any benefits paid for loss of life will be paid to the beneficiary. All other benefits will be paid to you, if living, otherwise to your beneficiary in accordance with preferential beneficiary order in absence of named beneficiary. If your estate will not be probated, the Provident may use its discretion in disbursing benefits which would otherwise be payable to your beneficiary in accordance with preferential beneficiary order in absence of named beneficiary, not to exceed \$2,000.00. The Provident will be discharged to the extent of any such payment made in good faith.

Physical Examination and Autopsy

The Provident will have the right to examine any person as often as it may require and to perform an autopsy where not forbidden by law. This will be at the expense of the Provident.

Legal Actions

No action may be brought to recover under the Plan until 60 days after proof of loss has been given. No action can be brought after 3 years from the date written proof of loss was required to be furnished.

CLAIM APPEAL PROCEDURES

Claims for benefits under the Plan are to be submitted to the Provident as provided herein. Payment of claims under the Plan will be made by the Provident. If an employee's claim for benefits under the Plan is denied, the employee will receive a written explanation giving detailed reasons for the denial, specific reference to policy provisions on which the denial is based, a description of any additional material or information necessary for the employee to perfect the claim and an explanation of why such material or information is necessary, as well as an explanation of Provident's claim appeal procedure.

If the employee is not satisfied, or does not agree with the reason for the denial of the claim, the employee may appeal the decision to Provident Life and Accident Insurance Company.

This appeal **must be in writing**, and can be made by the employee or a duly authorized representative. It must set out the reasons for the appeal and the employee's dissatisfaction or disagreement. Any evidence or documentation to support the employee's position should be submitted with the employee's written appeal. Upon written request, the employee may review pertinent documents that pertain to the employee's claim and its denial.

The employee's appeal must be made within 60 days of the date of receipt of the letter denying the claim.

Provident Life and Accident will promptly review the claim and appeal. It will advise the employee of its decision with specific references to pertinent policy provisions on which the decision is based. This written decision will be sent to the employee not later than 60 days after its receipt of the employee's written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining more information or conducting an investigation of the facts. In no event will the written decision be sent later than 120 days after Provident Life and Accident receives the employee's written appeal.

Life Insurance Claims

In the event of a claim, Aon Consulting should be notified immediately, and claim forms will be furnished to the beneficiary. Prompt payment will be made upon receipt of due proof of death.

Aon Consulting
Park Place, Suite 2000
1200 6th Avenue
Seattle, Washington 98101-1128
(206) 467-4646

Claims should be sent to:

UNUMProvident Insurance Company
Group Life Claims
P.O. Box 9060
Portland, Maine 04104
1-800-445-0402



THIS PLAN ARRANGED BY

Aon Consulting

Park Place Building, Suite 2000
1200 Sixth Avenue
Seattle, WA 98101-1128
(206) 467-4646
(8:00-4:30; Mon.-Fri.)

LIFE INSURANCE UNDERWRITTEN BY



Provident Life and Accident Insurance Co.
1 Fountain Square, Chattanooga TN 37402

MEDICAL BENEFITS UNDERWRITTEN BY



WEA SELECT SERVICE TEAM
7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124
Toll Free 1-800-722-1471
Hearing Impaired Toll Free TTY/TTD 1-800-842-5357

PLEASE NOTE

Only calls from the hearing-impaired
will be accepted on this line.