WEA
WASHINGTON
EDUCATION
ASSOCIATION

SELECT

Premera Blue Cross

WEA Select Plan 3

October 1, 2007

www.premera.com/wea

PREMERA BLUE CROSS

How To Contact Us

Customer Service

WEA Select Service Team

1-800-932-9221
Hearing Impaired TDD 1-800-842-5357

Contact the WEA Select Service Team for help with:

- Benefits, claims and eligibility
- Care and service questions or complaints
- Address and other personal information changes
- Forms

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

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

Physical Address
7001 220th St. SW
Mountlake Terrace, WA 98043-2124

Medco By Mail *(mail-order pharmacy)*

1-800-626-6080 or
www.premera.com/wea

BlueCard® Program

Out-of-state network providers
1-800-810-2583 or
www.bluecares.com/healthtravel/finder

Online Information

www.premera.com/wea

- Forms
- Benefit booklet and summary of benefits
- Provider directory
- Pharmacy information
- Claims status and online Explanation of Benefits
  Non-registered users please call the WEA Select Team for a PIN
- Resources for researching health topics
- Extras! discounts for plan enrollees

WASHINGTON EDUCATION ASSOCIATION
SELECT MEDICAL PLAN 3 (HERITAGE)

HOW TO CONTACT US (INSIDE FRONT COVER)

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), Premera Blue Cross (Medical Plan Underwriter) and UnumProvident Life and Accident Insurance Company (Life Insurance Underwriter).

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

The WEA Benefits Services Advisory Board reviews all plan benefits and limitations, and they are approved by the WEA Board of Directors. Your suggestions for plan improvements are always welcome and may be forwarded to the WEA or Aon Consulting.

To understand how your benefits are paid, please review this booklet when you enroll. As you incur medical expenses, you may wish to review the section which applies to them.

Premera 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: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

Group Name: .....Washington Education Association
Plan Year: .....October 1, 2007 – September 30, 2008
Group Number: .....WEA Select Medical Plan 3 (Heritage)
Contract Form Number: 1223W

KEEPING COSTS DOWN

We are all aware that health care costs continue 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 health care services. You can help limit health care cost increases by taking the following simple steps whenever possible:

- When hospital or medical services are necessary, seek care from a network provider.
- Seek medical help in a physician's office rather than a hospital emergency room.
- Receive treatment for simple surgeries, diagnostic and preadmission tests as an outpatient or in the physician's office.
- Use your prescription drug benefit wisely by substituting generic drugs if your doctor agrees, and using home delivery services for maintenance drugs.

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 Preventive Care, must meet all of the following criteria:

- They must be, in the judgment of Premera Blue Cross, medically necessary and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- They must be furnished in connection with the diagnosis or treatment of a covered illness or 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 plan.
- Expenses must be incurred while the enrollee is covered under this plan and after any applicable waiting period required under this plan 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 services are medically necessary or are covered benefits.

Throughout the booklet, we use many terms that have specific meaning under this plan. Please see the "Definitions" section of the booklet for details. The terms "you" and "your" refer to the enrollees under this plan. The terms "we," "us," and "our" refer to Premera Blue Cross.

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

In this section of your booklet you will find information on how to manage your health care costs and out-of-pocket expenses through your choice of providers.

How your plan works

Your WEA Select Plan is called a "Heritage" plan. It uses a network of contracted providers (known as "Heritage Network") to provide health care services to you. These providers are also called "network providers." The plan makes available to you sufficient numbers and types of providers to give you access to all covered services in compliance with applicable state regulations governing access to providers. Your plan provides the higher level of benefits (and lower out-of-pocket costs) when you use Heritage Network providers.

The plan also features an out-of-network option. When you use a licensed health care provider who is not part of the Heritage network (also called a "Non-Heritage," “Heritage Plus 1” or out-of-network provider) benefits for covered services are provided at a lower level of benefits (and higher out-of-pocket costs).

Provider Type	**Heritage (In Network)**	**Non-Heritage (Out-of-Network; also called Heritage Plus 1)**
Action to take	Before receiving services, confirm that your provider is a Heritage provider	Before receiving services, confirm that your provider is not part of the Heritage network
Result	• You receive the higher level of benefits and pay lower out-of-pocket expenses for most services • No paperwork (providers submit claims directly to us) • No balance billing	• You receive the lower level of benefits and pay higher out-of-pocket expenses* • You may have to submit claims to us • You may be balanced billed for charges over Premera’s allowable amount

*There are a few exceptions. Certain services are always paid at the higher level of benefits. For a list of these services, please see the bullet points on the next page in "How Selecting a Provider Affects Your Out-of-Pocket Expenses."

FINDING NETWORK PROVIDERS AT HOME AND AWAY FROM HOME

Network providers are available throughout the United States. The names of networks will be different, depending on where you are receiving services:

When you are in:	**Use this provider type to get the higher level of benefit and have lower out-of-pocket expenses:**
Washington	Premera Blue Cross Heritage providers
Alaska	Premera Blue Cross Blue Shield of Alaska preferred and participating providers
Wyoming, Maine	The local Blue Cross and/or Blue Shield Licensee’s Traditional providers**
All other states	The local Blue Cross and/or Blue Shield Licensee’s PPO provider network**

**To help you manage the cost of health care, you access network providers in states other than Washington and Alaska through the BlueCard program, which has arrangements with Blue Cross and/or Blue Shield plans throughout the country to furnish covered services to you. This network consists of hospitals and other health care facilities, physicians and professionals. See "The BlueCard Program" later in this section for more information about how BlueCard works.

FINDING A NETWORK PROVIDER

The directory of network providers in Washington and Alaska is available on our Web site at www.premera.com/wea. You can also get current provider information by contacting the WEA Select Service Team at 1-800-932-9221. To locate a network provider in other states, please call 1-800-810-BLUE (2583) or go to the BlueCard Web site at: www.bluecares.com/healthtravel/finder.html.

How selecting a provider affects your out-of-pocket expenses

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

Your choice of a particular provider may affect your out-of-pocket costs. Different providers in each network may have contracted to accept different allowable charges as payment in full even though all the contracts are with the same Blue Cross and/or Blue Shield licensee. You'll never have to pay more than your share of the allowable charge when you use network providers. See "What Are My Benefits" for information on copays, deductibles and coinsurance that you are required to pay.

If the provider you choose isn't a network provider, you'll get the lower level of benefits under this plan for covered services and supplies, except as stated otherwise below. You'll also be responsible for amounts above the allowable charge, in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services and supplies. Amounts in excess of the allowable charge do not count as coinsurance.

The following services and/or providers will always be covered at the higher level of benefits:

- Care for a "medical emergency" (please see the "Definitions" section in this booklet).
- Services by certain categories of providers (such as alcohol treatment facilities, blood banks and ambulance companies located in Washington) to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services in Washington or Alaska at a non-contracting hospital, if admitted by a network provider without admitting privileges at a Washington or Alaska network hospital.

EXPENSES

To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for paying. Please see the "What Types Of Expenses Am I Responsible For Paying" section in this booklet for information on calendar year deductibles, copayments and coinsurance.

WHAT IS THE ROLE OF CARE MANAGEMENT AND CASE MANAGEMENT?

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 plan'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 plan'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 plan would be available to you at that time.

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

APPEALS REVIEW

Should you or your provider disagree with a Care Management determination, please refer to the procedures outlined under the "What If I Have A Question or Want to Appeal a Claim Decision" section.

HOW DO I SUBMIT A CLAIM?

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

1. Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. Use the Subscriber Claim Form, available at www.premera.com/wea or by calling the WEA Select Service Team at 1-800-932-9221.
2. Attach an itemized bill from the provider. Bills will not be considered to be claims until all the necessary information is included.
3. Sign the form in the space provided.
4. Mail your claim to:

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

TIMELY FILING OF CLAIMS

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.

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 SERVICES

For hospital services, present the Premera Blue Cross identification card to the admitting clerk when admitted to or receiving outpatient services at 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 admitted to or receiving outpatient services at a hospital not contracted with Premera Blue

Cross (Non-Heritage hospital) and the hospital does not bill, submit the itemized bill to us along with a Subscriber Claim Form. You will receive payment directly in order to pay your hospital bills.

PHYSICIAN AND OTHER PROVIDER SERVICES

Heritage Providers

Present the 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.

Heritage providers will seek payment for covered services solely from Premera Blue Cross and accept our payment as payment in full. Heritage providers may seek payment from you only for the following:

- Services and/or charges not covered by this plan
- Copays, deductible and coinsurance
- Amounts in excess of stated benefit maximums

Non-Heritage Providers

If you receive services from a provider that has not contracted with Premera Blue Cross and the Subscriber Claim Form indicates that full payment has been made, payment for covered services will be made directly to the enrollee. 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.

Non-Heritage providers may seek payment from you for the following:

- Amounts above the allowable charge (the difference between what we allow for the service and the provider's actual charge)
- Services and/or charges not covered by this plan
- Copays, deductible and coinsurance
- Amounts in excess of stated benefit maximums

Include the group and subscriber identification numbers on all bills or correspondence. The numbers are listed on your Premera Blue Cross identification card.

For information on how to submit claims from out-of-area providers, please see "The BlueCard® Program (out-of-area services)."

WHAT DO I DO IF I'M OUTSIDE WASHINGTON AND ALASKA?

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 receive covered services in Clark County, Washington or outside Washington and Alaska from hospitals, doctors, and other medical care providers who have contracted with the local Blue Cross and/or Blue Shield licensee, called the "Host Blue" in this section. The national BlueCard program is available throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

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

How the BlueCard Program helps keep costs down

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

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

The methods used to determine the negotiated price will vary among Host Blues according to the terms of their provider contracts. Often the negotiated price will consist of a simple discount, which reflects the actual price allowed as payable by the Host Blue. But sometimes it 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.

Clark County providers

Some providers in Clark County, Washington, do have contracts with Premera Blue Cross. These providers will submit claims directly to us and benefits will be based on our allowable charge for the service or supply.

Non-BlueCard claim submission

If a hospital, doctor, or other medical care provider does not contract with the Host Blue, that claim 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 â

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).

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)."

- **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 1-800-932-9221.
- **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 at the address noted on page 5 or on the claim form.
- **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 out-of-country 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.

FURTHER QUESTIONS?

If you have questions or need additional information about using your identification card in Clark County, Washington, or outside Washington and Alaska, please call our 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 Web site at www.bluecares.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 network provider.

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

REVOLVING FIVE-YEAR BENEFIT MAXIMUM

Your plan pays $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, 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 a new contract replaces this one, or if the enrollee becomes covered by another WEA Select Health Care Plan, any amounts which have been used toward the maximum will transfer to the new contract.

COPAYMENTS

A copayment (also called a "copay") is a fixed dollar amount that you must pay for certain services and supplies. You are required to pay a copay for most services from Heritage and non-Heritage providers. Copays do not apply toward the calendar year deductible or coinsurance maximum.

Your plan requires the following copays:

- **Inpatient Hospital**.....$300 per day to $900 maximum per calendar year
- **Outpatient Surgery** .....$150 per surgery
- **Emergency Room Visits** .....$100 per visit (waived if admitted, then required to pay the appropriate copay, deductible and coinsurance for the hospital admission)
- **Home Health Care**.....$100 per calendar year
- **Hospice Care** .....$100 per calendar year
- **Skilled Nursing Facility**.....$100 per calendar year
- **Office Visits**
  - **Heritage Providers**.....$30 per visit
  - **Non-Heritage Providers** .....$40 per visit
- **Prescription Drug Copays** .....See the "Prescription Drugs" benefit on page 15

CALENDAR YEAR DEDUCTIBLE

The calendar year deductible is the amount you must pay each year before your plan benefits are available to you. It applies to **all** benefits, except as specified. Your calendar year deductible is:

- $200 per enrollee and $600 for each family.

Please note:

- The calendar year deductible is in addition to any required coinsurance and copays.
- Copayments (including, but not limited to, office visits, spinal manipulations, naturopathic services, acupuncture, emergency room services, outpatient rehabilitation therapy, outpatient neurodevelopmental therapy, and prescription drugs) do not apply toward the calendar year deductible.
- Allowable charges that apply to your calendar year deductible do not count toward dollar benefit maximums. (Please note that some benefits carry a different kind of maximum, such as number of visits or days of care.)
- A new deductible is required at the start of each calendar year. However, expenses you incur in the last three months of a calendar year for covered services and supplies that satisfy all or part of the calendar year deductible will also satisfy all or part of the next year's deductible. This is also true for the family calendar year deductible. (Please note that the deductible credited from a prior calendar year does **not** reduce the next year's out-of-pocket maximum.)
- The amount credited toward the calendar year deductible for any covered service or supply won't exceed the allowable charge.

COINSURANCE

Coinsurance is a percentage of the allowable charge that you must pay for certain services and supplies. Coinsurance does not apply toward copays or the calendar year deductible. See Section 2-Specific Benefits and Section 3-General Benefits for details.

WHAT ARE MY BENEFITS?

SECTION 1—SPECIFIC BENEFITS

The following benefits are detailed below. They are not subject to the General Benefits Reimbursement Formula (coinsurance), nor are they subject to the revolving five-year maximum.

- Acupuncture Services
- Audio (Hearing)
- Hospice Care
- Naturopathic Services
- Nicotine Dependency
- Nonsurgical Treatment of Morbid Obesity
- Outpatient Mental Health
- Outpatient Neurodevelopmental Therapy
- Outpatient Rehabilitative Care
- Physician Visits (Office and Home)
- Prescription Drugs
- Preventive Care

Covered Services for Section 1 – Specific Benefits

Acupuncture Services

Benefits are provided for medically necessary acupuncture services to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition. Covered services will be paid **up to 12 visits per calendar year** as follows:

- **Heritage Providers:** ..... $30 copay
- **Non-Heritage Providers:** ..... $40 copay

Acupuncture services are not subject to your calendar year deductible.

Audio (Hearing)

After satisfying the calendar year deductible, benefits are provided **up to a maximum plan payment of $400** over three consecutive calendar years for each enrollee as follows:

- **Heritage Providers:** You pay 20% of allowable charges, plan pays 80% of allowable charges
- **Non-Heritage Providers:** You pay 20% of allowable charges, plan pays 80% of allowable charges

Benefits include:

- One otologic exam by a physician
- One audiologic exam and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation
- Hearing aid (monaural and binaural) prescribed as a result of the exam
- Ear mold(s)
- Hearing aid instrument
- Initial batteries, cords and other necessary ancillary equipment
- Warranty
- Follow-up consultation within 30 days of receiving the hearing aid
- Repair of hearing aid equipment

If you return the hearing aid before actually purchasing it, you will pay 20% of allowable rental charges for a maximum 30 days.

In addition to the limitations and exclusions elsewhere in this book, audio benefits will not be provided for:

- Hearing aid replacement more than once in three consecutive calendar years
- Batteries or other ancillary equipment except that obtained at the initial purchase of the hearing aid
- Routine maintenance or alteration of hearing aid equipment
- A hearing aid which exceeds the prescribed specifications for correction of hearing loss

- Expenses incurred after your coverage ends unless the hearing aid was ordered before that date and delivered within 45 days after coverage ends
- Hearing aids ordered or purchased before your effective date of coverage
- Charges in excess of the audio benefit

Hospice Care

Benefits will be available only during the enrollee's last six months of life, as determined by the patient's physician and beginning on the first day of covered hospice care, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, plan pays 100% of allowable charges; subject to a $100 annual copay
- **Non-Heritage Providers**: After meeting the calendar year deductible, plan pays 100% of allowable charges; subject to a $100 annual copay

To be covered, hospice care services must be furnished and billed by a Medicare-certified hospice agency or state-licensed or state-certified hospice agency in the state in which it operates. Services must be part of a written plan of care prescribed and periodically reviewed by a physician (M.D. or D.O.) and subject to Premera Blue Cross's utilization review. The plan of care must describe the services and supplies for the palliative care and medically necessary treatment to be provided to the enrollee. The 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 six-month period begins on the initial date of hospice care covered under this plan

Home care up to a maximum of six months is provided 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)
- 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 240 hours of respite care** for a homebound enrollee in each six-month period of hospice care

You are also covered **up to 10 days of inpatient care** in a hospice that is Medicare-certified or state-licensed or state-certified by the state in which it operates when ordered by the attending physician (M.D. or D.O.).

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.

Naturopathic Services

Benefits for covered services by a licensed naturopathic physician (N.D.) are provided as follows:

- **Heritage Providers:** ..... $30 copay
- **Non-Heritage Providers:** ..... $40 copay

Naturopathic services are not subject to your calendar year deductible.

Benefits are not provided for hair analysis, non-prescription drugs, or homeopathic or naturopathic remedies, medicines and devices.

Nicotine Dependency

Benefits are provided **up to a $250 lifetime maximum** for classes, programs and other services customarily used in a formal treatment program to help the enrollee quit using tobacco. Treatment must be performed by a recognized organization, group or individual known to normally and routinely provide treatment as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 50% of actual charges; plan pays 50%
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 50% of actual charges; plan pays 50%

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.

For nicotine dependency prescription drugs and supplies benefit information, see "Prescription Drugs" on page 15.

Nonsurgical Treatment of Morbid Obesity

Benefits are provided **up to a $750 lifetime maximum** as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50%
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50%

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. Eligible expenses are limited to Premera-approved services provided by a physician-supervised (M.D. or D.O.) structured weight loss program, related exams and laboratory work.

The benefit does not include:

- Weight loss drugs
- Food supplements or replacements
- Weight loss programs not supervised by a physician, even when the enrollee's participation is prescribed or recommended by a physician

Please call the WEA Select Service Team at 1-800-932-9221 for details.

Outpatient Mental Health

This benefit provides outpatient treatment of mental health conditions, including treatment of eating disorders such as anorexia nervosa, bulimia or any similar condition. Services must be consistent with generally recognized standards within a relevant health profession as determined by the plan.

Outpatient Care When not confined as a bed patient in a hospital, **up to 30 one-hour visits** for medically necessary services for mental health conditions are provided each calendar year for each

enrollee. If the provider bills for charges that exceed one hour, each additional hour or portion of an hour will count as an additional visit toward the 30-visit maximum. For example, a single two-hour session will count as two visits. Benefits are provided a follows:

- **Heritage Providers:** ..... $30 copay
- **Non-Heritage Providers:** ..... $40 copay

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 (ARNP), a Licensed Clinical Social Worker (LCSW), a State-Certified Clinical Social Worker (CCSW), a State-Certified Mental Health Counselor (CMHC), any other state-certified master's-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 a plan in effect 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 of covered benefits for mental health services under this plan than provided here, or if you have a question or concern about any aspect of your mental health benefits, please contact Premera Blue Cross at:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

For 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, contact the Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Department of Health at (360) 236-4010.

Outpatient Neurodevelopmental Therapy

Benefits are provided when the enrollee is **not** confined in a hospital.

Benefits are provided **up to 45 visits** per calendar year for enrollees age 6 or under for all forms of therapy combined. A "visit" is a session of treatment for each type of therapy. Each type of therapy accrues toward the visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different providers. Benefits are provided as follows:

- **Heritage Providers:** ..... $30 copay
- **Non-Heritage Providers:** ..... $40 copay

Outpatient neurodevelopmental therapy services are not subject to your calendar year deductible.

Benefits may include speech and hearing therapy, physical therapy, massage therapy, rehabilitative counseling and functional occupational therapy when it meets all of the following criteria:

- The care restores or improves lost body functions, or maintains function, related to neurodevelopmental delay or deficiencies (neurological and body functions that fail to develop normally after birth) where, in our judgment, significant deterioration would occur without the services.
- Treatment is appropriate to the condition being treated.
- Services must be furnished and billed by a legally operated hospital, by a physician (M.D. or D.O.), or by a massage practitioner, physical, occupational or speech therapist.

Benefits are not provided for:

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

Please see "What's Not Covered" for additional limitations and exclusions.

Outpatient Rehabilitative Care

Benefits are provided when the enrollee is **not** confined in a hospital.

Benefits are provided **up to 45 visits** for all services combined per calendar year, as follows:

- **Heritage Providers:** ..... $30 copay
- **Non-Heritage Providers:** ..... $40 copay

Outpatient rehabilitative care services are not subject to your calendar year deductible.

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. Care is given by a licensed or registered therapist and begins within one year of the date the condition began.

This care does not include physical therapy, which is included under Section 3-General Benefits.

Benefits are not provided for:

- Nonmedical self-help, such as "Outward Bound" or "Wilderness Survival"; recreational or educational therapy
- Social, cultural, and vocational therapy
- Acupressure
- Services provided by employees of a home health agency or hospice

Please see "What's Not Covered" for additional limitations and exclusions.

Physician Visits (Office and Home)

The plan pays for one visit per physician (as defined in the "Definitions") per day in the physician's office or enrollee's home. This benefit includes surgical opinion consultations for any covered diagnosis.

- **Heritage Providers:** ..... $30 copay
- **Non-Heritage Providers**: ..... $40 copay

Physician visits (office and home) are not subject to your calendar year deductible.

A "visit" is a personal interview between the enrollee and the physician, including spinal manipulations, and does not include any visit in which the doctor does not personally see the patient. Naturopathic services are covered as outlined on page 12.

The following are not covered under this benefit:

- Any related charges, such as diagnostic X-ray and laboratory services, which may be covered under the "Diagnostic Imaging and Laboratory Services" benefit. See page 24.
- 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 care, psychiatric conditions, nonsurgical treatment of morbid obesity, nonsurgical treatment of TMJ, or chemical dependency. These services may be covered under other benefits.

Please see "What's Not Covered" for additional limitations and exclusions.

Prescription Drugs

The following topics are detailed below:

- Retail Pharmacy Prescriptions
- Medco By Mail/Mail-Order Pharmacy Prescriptions
- Specialty Pharmacy Prescriptions
- Injectable Supplies
- What's Covered
- Exclusions
- Prescription Drug Volume Discount Program
- Your Right to Safe and Effective Pharmacy Services
- Questions and Answers About Your Prescription Drug Benefits

This benefit covers medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for use outside of a medical facility and dispensed by a licensed pharmacist in a state-licensed pharmacy where it is located. Also included are injectable supplies (please see "Injectable Supplies" below for more information). A prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription."

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 about your prescription drugs' tiers and other pharmacy 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 new prescription or refill. **Please Note:** Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don't apply to this benefit. Similarly, copays required under this benefit don't apply to other benefits of this plan. Please also note in no case will the enrollee's out-of-pocket expense exceed the cost of the drug or supply.

Retail Pharmacy Prescriptions: Up to a 34-day supply is covered unless the drug maker's packaging limits the supply in some other way for:

Tier 1 - Generic Drugs ..... $15 copay

Tier 2 - Preferred List Brand Name Drugs ..... $25 copay

Tier 3 - Non-Preferred List Brand Name Drugs ..... $40 copay

- **Participating Retail Pharmacies:** Be sure to present your identification card to the pharmacist for all prescription drug purchases to avoid paying the retail cost for a covered prescription drug.
- **Non-participating Retail Pharmacies:** You pay the full price for the drug(s) and submit a claim (please see the "How Do I File A Claim" section for more information). You will be reimbursed for 60% of the allowable charge, after your copay. 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 non-participating pharmacy, including those filled via mail or other home delivery service.

  For a list of participating pharmacies, please call the WEA Select Service Team at 1-800-932-9221 or the toll-free Pharmacy Locator Line on the back of your Premera Blue Cross ID card. You may also find pharmacies at www.premera.com/wea and click on Provider Directory in the left-hand column.

Medco By Mail/Mail-Order Pharmacy Prescriptions: This benefit is limited to our participating home delivery pharmacy. **Up to a 100-day supply** covered unless the drug maker's packaging limits the supply in some other way for:

Tier 1 - Generic Drugs ..... $15 copay

Tier 2 - Preferred List Brand Name Drugs ..... $25 copay

Tier 3 - Non-Preferred List Brand Name Drugs ..... $40 copay

You can often save time and money by filling your prescriptions through our Medco By Mail/Mail-Order Pharmacy program. To use it, ask your physician to prescribe medications for up to the above maximum dispensing limit plus refills. If presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply of each drug when you submit a new prescription or refill.

For more details about, and/or forms for, the mail-order pharmacy program, call Medco Health customer service at 1-800-626-6080 or visit our Web site at www.premera.com/wea, click on Pharmacy in the left-hand column, click on Pharmacies/Mail Service along the top of the page.

Specialty Pharmacy Prescriptions: Up to a 30-day supply of specialty pharmacy drugs will be covered, subject to the following copays:

Tier 1 - Generic Drugs ..... $15 copay

Tier 2 - Preferred List Brand Name Drugs ..... $25 copay

Tier 3 - Non-Preferred List Brand Name Drugs ..... $40 copay

"Specialty drugs" are medications that require special handling, storage or transport, or patient monitoring to determine medical effectiveness. They are used to treat complex or rare conditions, including multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Specialty drugs can be dispensed from a participating retail pharmacy or by one of the specialty pharmacies. For more information about this program, the pharmacies and a list of specialty drugs, please visit www.premera.com/wea, click on Pharmacy in the left-hand column, then Pharmacy Programs. Or you can call the WEA Select Service Team at 1-800-932-9221.

Injectable Supplies: When hypodermic needles and syringes are purchased along with the related insulin a single copay for all items dispensed will apply.

When insulin hypodermic needles and syringes are purchased separately from the related insulin, the Preferred List Brand Name Drug (Tier 2) copay will apply for each item dispensed, providing you have a written prescription from your health care provider for each item.

For injectable drugs other than insulin, a separate Preferred List Brand Name Drug (Tier 2) copay will apply for each item dispensed.

The Preferred List Brand Name Drug (Tier 2) 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.

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 "Definitions").
- 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 nicotine dependency drugs, up to $250 per enrollee 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 found in Section 3-General Benefits under "Prosthetics, Orthotics and Medical Equipment" on page 30."

For immunization agents and vaccines, including the professional services to administer them, please see the "Preventive Care" benefit on page 19.

Exclusions: This benefit doesn't cover:

- Drugs and medicines that may be lawfully obtained without a prescription (over the counter, or OTC). OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples include, but aren't limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g., infant formulas or protein supplements)
- Non-prescription contraceptive methods (e.g., jellies, creams, foams or devices)
- Drugs for cosmetic use, or which promote or stimulate hair growth
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives, which are covered under other benefits 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 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, growth hormone and glucagon); please see the "Home Infusion Therapy" benefit on page 26.
- Drugs to treat infertility, including fertility enhancement medications
- Weight loss drugs

Prescription Drug Volume Discount Program: Premera Blue Cross participates in a program that provides discounts on the costs of certain prescription drugs used by our enrollees. The total net savings generated by the volume discount program is calculated annually and 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, 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 (sometimes 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 (FDA) 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.

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

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 non-preferred status, we'll notify you before the change. The amount you pay for a drug is based on the drug's designation (as a generic, preferred or non-preferred drug) on the date it's dispensed. The pharmacy's status as participating or 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 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 mail order pharmacy benefit is described under "Prescription Drugs."

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

Yes. You receive the higher 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 non-participating pharmacy, but at a higher out-of-pocket cost to you as explained above.

You can find a participating pharmacy near you by consulting your provider directory (online at www.premera.com/wea, click on Provider Directory in the left-hand column), 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, home delivery

pharmacy, and specialty pharmacy benefits are described in "Prescription Drugs."

In certain circumstances, we may limit benefits for a specific drug, dosage or strength, or limit the quantity appropriate for the 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 enrollee has used 75% of the current supply. The 75% is calculated based on the number of units and days supply dispensed on the last refill.

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

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

Preventive Care

Benefits are provided **up to $300 per calendar year** (**$600 per calendar year for enrollees from birth through age 3**) for each enrollee for routine physical examinations, including examinations required for school, sports or employment and well-baby examinations as follows:

- **Heritage Providers:** The plan pays 100% of allowable charges
- **Non-Heritage Providers**: You pay 20% of allowable charges; plan pays 80% of allowable charges

Preventive care is not subject to your calendar year deductible.

This benefit includes outpatient routine or preventive diagnostic imaging (including x-ray), laboratory services and immunizations, which are also provided at 100% of allowable charges when part of your preventive care with a Heritage Provider. All outpatient non-preventive diagnostic imaging (including x-ray), screening and diagnostic mammography, and laboratory services are paid under the "Diagnostic Imaging And Laboratory Services" on page 24.

Approved wellness classes through physicians and hospitals are also covered. Most providers require you to pay for classes at the time of service. For reimbursement, complete a Subscriber Claim Form and send it with the provider's bill to the claims address as noted in "How Do I Submit A Claim."

Preventive care benefits *are not* available for:

- Services related to a specific illness, injury or a definitive set of symptoms, (these may be covered under other benefits)
- Vitamins or nutritional supplements
- Dental examinations or treatment, the fitting of dental appliances or dentures, or other services provided by a licensed dentist or denturist
- Services for eye examinations or the fitting of eyeglasses or contacts
- Routine fitness testing, such as aerobic capacity, flexibility, body fat percentage, etc.
- Services for a routine or diagnostic mammogram or prostate cancer screening (covered under "Diagnostic Imaging and Laboratory Services" on page 24.)
- Physical exams for life or disability insurance
- Work-related disability evaluations or medical disability evaluations

Please also see "What's Not Covered" for additional limitations and exclusions.

SECTION 2—SPECIFIC BENEFITS

The following benefits are detailed below. They are not subject to the Coinsurance/General Benefits Reimbursement Formula (GBRF) but they are subject to the revolving five-year maximum.

- Inpatient Mental Health
- Nonsurgical Temporomandibular Joint (TMJ) Dysfunction

Covered Services for Section 2 – Specific Benefits

Inpatient Mental Health

This benefit provides inpatient treatment of mental health conditions, including treatment of eating disorders such as anorexia nervosa, bulimia or any similar condition. Services must be consistent with generally recognized standards within a relevant health profession as determined by the plan.

Inpatient Care When confined as a bed patient in a legally operated hospital or a state hospital operated and maintained by the State of Washington for the care of the mentally ill, benefits for physician and hospital services to treat the covered mental condition are provided **up to 30 days per calendar year** as follows:

- **Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 40% of allowable charges; plan pays 60% of allowable charges

Partial psychiatric hospitalization may be used in lieu of inpatient care when deemed medically appropriate by the plan. Every two days of partial psychiatric hospitalization will count as one day of the inpatient benefit limit. For psychiatric partial day care, you pay half of the applicable inpatient copay per partial day.

Benefits are not provided for residential treatment. However, outpatient mental health care services from licensed or certified providers received while in residential treatment may be covered if we determine they are medically necessary.

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

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

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 (ARNP), a Licensed Clinical Social Worker (LCSW), a State-Certified Clinical Social Worker (CCSW), a State-Certified Mental Health Counselor (CMHC), any other state-certified master's-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 a plan in effect 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 of covered benefits for mental health services under this plan than provided here, or if you have a question or concern about any aspect of your mental health benefits, please contact Premera Blue Cross at:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

For 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, contact the Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Department of Health at (360) 236-4010.

Nonsurgical Temporomandibular Joint (TMJ) Dysfunction

Inpatient and outpatient facility and professional care, including professional visits, are covered **up to a maximum lifetime benefit of $1,000** per enrollee, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 50% of allowable charges; plan pays 50% of allowable charges

Medical services and supplies are those that are:

- Reasonable and appropriate for treating TMJ, given all the facts of the case and
- Effective for the control or elimination of pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food caused by TMJ and
- Effective and meet professional standards of good medical or dental practice and
- Not experimental or investigational, as determined by us according to the criteria stated under "Definitions" or
- Not primarily for cosmetic purposes

Benefits are not available 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 for TMJ.

Benefits for covered hospital and professional services required for the surgical treatment of TMJ dysfunction or myofascial pain-dysfunction (MPD) are covered under Surgical and Medical Benefits, Section 3-General Benefits, below.

SECTION 3—GENERAL BENEFITS

You are responsible for copays, deductible and coinsurance, where applicable. Section 3-General Benefits are also subject to the revolving five-year maximum.

Some benefits have a copay:

Inpatient.....$300 per day to $900 maximum per person per calendar year
Home Health Care.....$100 per calendar year
Outpatient surgery.....$150 per surgery
Skilled Nursing Facility.....$100 per calendar year
Emergency Room.....$100 per visit (waived if admitted)

Your deductible is $200 per person or $600 per family per calendar year.

The Coinsurance/General Benefits Reimbursement Formula (GBRF) is the percentage of allowable charges you pay, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

After the plan pays $10,000 in benefits per enrollee, all in-network and out-of-network coinsurance/GBRF services are covered at 100% of allowable charges for the rest of the calendar year.

Copays and deductibles do not count toward the $10,000.

Please see the “Definitions” section for more information on allowable charges.

The following benefits are detailed in the "Covered Services" section below:

- Ambulance Services
- Anesthesia (see Surgical and Medical Care)
- Blood and Blood Products
- Chemical Dependency Treatment
- Chemotherapy (see Surgical and Medical Care)
- Contraceptive Services
- Dental Services
- Diagnostic X-ray and Laboratory Services
- Dietary Formula (PKU)
- Emergency Room Services
- Health Education
- Home Health Care
- Home Infusion Therapy
- Hospital Services (Inpatient and Outpatient)
- Inpatient Neurodevelopmental Therapy
- Inpatient Rehabilitative Care
- Mastectomy and Breast Reconstruction
- Newborn Care
- Obstetrical (Maternity) Care
- Physical Therapy
- Prosthetics, Orthotics and Medical Equipment
- Psychological and Neuropsychological Testing
- Skilled Nursing Facility
- Surgical and Medical Care (Professional)
- Surgical Treatment of Temporomandibular Joint Dysfunction (TMJ)
- Transplants
- X-Ray, Radium and Radioactive Isotope Therapy (see Surgical and Medical Care)

General Benefits with Specific Benefit Level Maximums

Chemical dependency.....$13,500 in a 24-consecutive-month period
Inpatient rehabilitative care.....30 days each calendar year
Inpatient neurodevelopmental therapy.....30 days each calendar year
Transplants.....$250,000 lifetime maximum
Skilled nursing facility.....130 days each calendar year

Covered Services for Section 3 – General Benefits

Ambulance Services

Benefits are provided for licensed ambulance service to the nearest facility equipped to treat the condition only when other means would endanger your health and safety. This benefit is not available for private automobiles or taxi services, nor for the convenience of the patient or family.

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Anesthesia Services (See "Surgical and Medical Care")

Blood and Blood Products

Benefits are provided for blood products and their administration.

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Chemical Dependency Treatment

Benefits will be provided **up to a maximum of $13,500** per enrollee for all inpatient and outpatient services combined during any 24-consecutive-month period as follows:

Inpatient Facility Care

- **Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 40% of allowable charges; plan pays 60% of allowable charges

Inpatient Professional Services

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Outpatient Facility Care

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Outpatient Professional Visits

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Covered services include medically necessary inpatient and outpatient services, including methadone treatment, when received from a state-approved facility or program for the treatment of chemical dependency. Medically necessary, covered therapeutic and supporting services for enrolled family members to assist in the patient's diagnosis and treatment are subject to the benefit maximum(s) of the patient undergoing treatment.

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 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.

Chemical dependency benefits *will not* be provided for:

- Voluntary support groups such as Alanon, Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous
- Separate charges for transportation, records and reports

- 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
- Please see "What's Not Covered" for other limitations and exclusions

Treatment for detoxification services will be paid as any other medical condition and does not apply towards the chemical dependency benefit limit above.

Chemotherapy (See Surgical and Medical Care)

Contraceptive Services

Benefits are provided for contraception services, drugs and supplies noted below as for any other covered care.

- Prescription drugs and devices for contraception: See "Prescription Drugs" on page 15.
- Contraceptive surgeries, implants and injections: For surgical sterilization and implantable contraceptives (including hormonal implants), see "Surgical and Medical Care" on page 32." Injectable contraceptives and associated professional services are covered as any other therapeutic injection.
- Professional consultations and office visits: See "Physician Visits (Office and Home)" on page 14.

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

Dental Services

Benefits are provided for dental services for treatment of a fractured jaw or injury to functionally sound natural teeth if treatment is received within 12 months of the injury, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Benefits are provided for the repreparation or repair of the natural tooth structure and include the services of a licensed dentist (D.M.D. or D.D.S.) or denturist. This benefit will not be provided for injuries caused by biting or chewing. "Functionally sound natural teeth" means the affected teeth are living, natural teeth free from decay and do not, at the time of the injury, have extensive restoration, veneer, crowns or splints; periodontal disease or another condition that would have caused the teeth to be in a weakened state before the injury.

This plan 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 of the following two reasons:

1. 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;
2. 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.

Diagnostic Imaging and Laboratory Services

Diagnostic imaging and scans (including X-rays and EKGs), laboratory services, including prostate cancer screening, pathology tests and mammograms recommended by your physician, advanced registered nurse practitioner or physician's assistant are covered as follows:

- **Heritage Providers:** After meeting your deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting your deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

See also “Preventive Care” on page 19 for outpatient routine or preventive diagnostic imaging (including x-ray) and laboratory services.

Dietary Formula (PKU)

Benefits for dietary formula are provided to treat phenylketonuria (PKU) when medically necessary, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Emergency Room Services

Benefits are provided for services received from a hospital emergency room. You pay:

- Heritage Providers: $100 copay per visit*; your calendar year deductible and coinsurance also apply
- Non-Heritage Providers:$100 copay per visit*; your calendar year deductible and coinsurance also apply

*If admitted as an inpatient to a hospital, the emergency room services copay will be waived and you will be required to pay the appropriate hospital copay and coinsurance.

Health Education

Benefits are provided for outpatient health education to manage a covered condition, illness or injury. Examples include asthma, diabetes, pain management, childbirth and newborn parenting and lactation as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Home Health Care

Benefits are provided to homebound enrollees for the treatment of a covered medical condition or injury requiring medically necessary skilled care as follows:

- **Heritage Providers:** After meeting the calendar year deductible and the annual home health copay, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible and the annual home health copay, you pay 40% of allowable charges; plan pays 60% of allowable charges

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: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

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

- Provide skilled medical care, as described in this section*
- Be furnished and billed by a covered home health agency, as described in this section under "Covered Home Health Care Services"*
- In our judgment, be "medically necessary" and not maintenance or custodial care (see the Definitions section)*
- 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. 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.

Skilled medical care means services primarily to treat an illness or 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.

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 services are:

- Intermittent Skilled Home Care Visits. A visit requiring a reasonable amount of time to do a specific skilled medical service which 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. 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 prescribed by a physician, and provided and billed by the home health agency.

Skilled care does not include services that are primarily for ongoing maintenance of the enrollee's health, rather than treatment of an illness or injury, even if furnished by one of the above-named health care providers. In addition to exclusions and limitations stated under "What Your Plan Does Not Cover," benefits are 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
- Social services
- Psychiatric conditions
- Separate transportation charges

Home Infusion Therapy

For outpatient professional services, supplies, drugs and solutions required for infusion therapy, benefits will be paid as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Infusion therapy (also known as intravenous therapy) is the administration of fluids into a vein by means of a needle or catheter, most often for the following purposes:

- Maintain fluid and electrolyte balance
- Correct fluid volume deficiencies after excessive loss of body fluids

- Help enrollees who are unable to take sufficient volumes of fluids orally
- Provide prolonged nutritional support for enrollees with gastrointestinal dysfunction

This benefit doesn't cover:

- Charges in excess of the average wholesale price for drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements

Hospital Services (Inpatient and Outpatient)

Benefits are provided for the services of a legally operated hospital, including inpatient and outpatient care, as follows:

- **Inpatient Care:** Benefits are provided for room and board, related ancillary services, and use of an intensive, coronary or constant care unit as follows:
  - **Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 20% of allowable charges; plan pays 80% of allowable charges
  - **Non-Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 40% of allowable charges; plan pays 60% of allowable charges

Charges for radio, television, long-distance telephone calls, meals for guests and personal comfort items are not covered.

- **Outpatient Services:** Benefits are provided for covered services, as follows:
  - **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges; you pay a $150 copay for each outpatient surgery
  - **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges; you pay a $150 copay for each outpatient surgery

Inpatient Neurodevelopmental Therapy

Benefits are provided **up to 30 days** each calendar year in a legally operated hospital for enrollees age six or under, as follows:

- **Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 40% of allowable charges; plan pays 60% of allowable charges

Benefits may include speech therapy, physical therapy, massage therapy, rehabilitative counseling and functional occupational therapy when it meets all of the following criteria:

- The care restores or improves lost body functions, or maintains function, related to neurodevelopmental delay or deficiencies (neurological and body functions that fail to develop normally after birth) where, in our judgment, significant deterioration would occur without the services
- Treatment is appropriate to the condition being treated
- The treatment is part of a formal written program of treatment prescribed by a physician
- Services must be furnished and billed by a legally operated hospital, by a physician (M.D. or D.O.), or by a massage practitioner, physical, occupational or speech therapist

Benefits are not provided 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

Please see "What's Not Covered" for additional limitations and exclusions. See page 13 for "Outpatient Neurodevelopmental Therapy."

Inpatient Rehabilitative Care

Benefits are provided **up to 30 days** per calendar year, as follows:

- **Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible and inpatient hospital copay, you pay 40% of allowable charges; plan pays 60% of allowable charges

Care could include physical therapy, speech and hearing therapy, rehabilitative counseling, functional occupational therapy and massage therapy. Care is given by a licensed or registered therapist.

Benefits begin on the day after treatment becomes primarily rehabilitative and:

- The treatment is part of a continuous inpatient stay following acute treatment (admissions solely for rehabilitative care are not included)
- The services are necessary to restore or improve lost functions due to illness or injury
- The services are provided in a legally operated hospital with a specialized rehabilitative care department approved by Premera Blue Cross (call the WEA Select Service Team for a list of approved facilities)
- The treatment is part of a formal written plan of treatment prescribed by a physician and that requires a variety of rehabilitation services

Please see "What's Not Covered" for additional limitations and exclusions. Please see page 14 for "Outpatient Rehabilitative Care."

Mastectomy And Breast Reconstruction

Inpatient and outpatient benefits are provided for a mastectomy necessary due to illness or injury, as follows:

- **Heritage Providers:** After meeting the calendar year deductible and any applicable copays, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible and any applicable copays, you pay 40% of allowable charges; plan pays 60% of allowable charges

Consistent with the requirements of the Women's Health and Cancer Rights Act of 1998, this plan provides benefits for mastectomy-related services. 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
- Physical complications of all stages of mastectomy, including lymphedemas

Services are provided in a manner determined in consultation with the attending physician and the patient.

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 plan. 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 plan 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 plan will apply, subject to the child's own deductible, copay and coinsurance requirements.

Services must be ordered by the attending provider (a physician, a physician's assistant, a certified nurse

midwife, a licensed midwife or an advanced registered nurse practitioner) in consultation with the mother. Some examples include:

- **Hospital Care:** Hospital nursery care as determined 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.
- **Professional Care:** Inpatient newborn care and follow-up care consistent with accepted medical practice when 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 is also covered.

For immunizations and outpatient well-baby care, please see “Preventive Care" on page 19.

Obstetrical (Maternity) Care

Pregnancy, childbirth and voluntary termination of pregnancy are covered as any other condition for all covered enrollees. If the attending provider (physician, a physician’s assistant, a certified nurse midwife, a licensed midwife or an advanced registered nurse practitioner) bills a single fee for childbirth that includes prenatal and postpartum services, this plan will cover that fee as it would any other surgery. Obstetrical care benefits include:

- **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.
- **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 when 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

Physical Therapy

Benefits are provided for outpatient physical therapy, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

For inpatient physical therapy, please see "Inpatient Rehabilitative Care" on page 28 and "Inpatient Neurodevelopmental Therapy" on page 27.

Prosthetics, Orthotics and Medical Equipment

Benefits are provided for medical equipment, prosthetics and orthotics used in direct treatment of a covered illness or injury as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Medical Equipment benefits are provided for rental or, at our option, purchase of home medical equipment, such as:

- Crutches
- Diabetic equipment such as blood glucose monitor, insulin pumps and accessories to pumps, and insulin infusion devices
- Dialysis equipment
- Hospital-type beds
- Intermittent Positive Pressure Breathing Apparatuses
- Traction equipment
- Ventilators
- Wheelchairs

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, such as 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.

See the "Prescription Drugs" benefit on page 15 for coverage for diabetic testing supplies.

Prosthetics and Orthotics benefits are provided for prosthetics such as:

- Artificial limbs or eyes
- Braces
- Casts
- Splints
- Trusses
- 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 for non-diabetic conditions are limited to one pair per calendar year for all items combined.

Please Note: This benefit does not include prosthetics prescribed or purchased as part of a mastectomy or breast reconstruction. Please see the "Mastectomy and Breast Reconstruction" benefit on page 28 for coverage information.

This benefit does not include prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered as a surgical service. Items provided and billed by a hospital are covered under "Hospital Services" on page 27.

Disposable Medical Supplies benefits are provided for disposable medical supplies such as oxygen, bandages, and colostomy supplies. Disposable diabetic testing supplies are covered under the "Prescription Drugs" benefit on page 15.

Psychological and Neuropsychological Testing

Benefits are provided **up to a maximum benefit of 12 hours** per enrollee each calendar year for all services combined, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges

Covered services include neurological, psychological and mental health testing and evaluations, including interpretation, necessary to prescribe an appropriate treatment plan. This includes re-evaluations.

- Physical, speech or occupational therapy assessments and evaluations are provided under the "Outpatient Rehabilitation Therapy" benefit on page 14.
- Physical, speech or occupational therapy assessments related to neurodevelopmental therapy are covered under the "Outpatient Neurodevelopmental Therapy" benefit on page 13.

Skilled Nursing Facility

For the treatment of a covered medical condition or injury that requires medically necessary skilled care, you are covered at a participating facility **up to 130 days per calendar year** as follows:

- **Heritage Providers:** After meeting the calendar year deductible and the annual skilled nursing facility copay of $100, you pay 20% of allowable charges (plan pays 80% of allowable charges)
- **Non-Heritage Providers:** Not covered except as stated below

Services are limited to:

- 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 provider ("PPO") through the BlueCard Program

When facilities as noted above are used, covered services that are provided and billed by a participating skilled nursing facility include:

- Room, meals and general nursing care
- Routine laboratory examinations
- Physical, occupational, speech and respiratory therapy
- Medical supplies, prescription drugs and blood products

If the services of a participating skilled nursing facility are not available, please call Care Management at 1-800-932-9221.

Skilled medical care primarily treats an illness or injury with services that 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. It does *not* include services primarily for ongoing maintenance of the enrollee's health, 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

To be covered, skilled nursing facility care cannot be maintenance or custodial care. Care must be:

- Prescribed by your physician
- Require skilled medical care
- In our judgment, "medically necessary" and not maintenance or custodial care (see "Definitions") and
- Furnished and billed by a skilled nursing facility as defined in this section unless the services are to

treat a medical emergency or injury

Note: Benefits may not be provided for every service or supply the physician recommends. We may exclude or limit benefits unless services are both skilled medical care and medically necessary.

In addition to exclusions and limitations in "What's Not Covered," this benefit does not cover:

- Custodial or maintenance care (see "Definitions")
- 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

For more information, please call your WEA Select Service Team at 1-800-932-9221.

Surgical And Medical Care (Professional)

Covered services include surgical and medical care by a physician (diagnosis and treatment of a covered condition, surgery, services of an assistant surgeon and administration of anesthesia) and administration of chemotherapy, x-ray, radium and radioactive isotope therapy, therapeutic and allergy testing/injections as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges; if care received as an inpatient, also subject to the appropriate inpatient hospital copay
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges; if care received as an inpatient, also subject to the appropriate inpatient hospital copay

Facilities charges may apply; please see "Hospital Services" on page 27 for information on facility copays.

Please see "Physician Visits (Office and Home)" on page 14 for physician office calls.

When multiple or bilateral procedures are performed during the same operative session by one or more surgeons, benefits are 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 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 as follows:

- Injury to the:
  - spinal cord resulting in paraplegia or quadriplegia
  - pelvic nerves which are inoperable and result in loss of sensation and function
- 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
- 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 provided for:

- additional implant surgeries as a result of an unsuccessful procedure or for replacement of a prosthesis due to defects, injury or technological advancement
- sexual counseling relating to impotency or implantation surgery
- implantation of a penile prosthesis when the cause of impotence is primarily psychological in nature

Surgical Treatment of Temporomandibular Joint Dysfunction (TMJ)

Benefits for covered hospital and professional services required for the surgical treatment of TMJ dysfunction and myofascial pain dysfunction are covered, as follows:

- **Heritage Providers:** After meeting the calendar year deductible, you pay 20% of allowable charges; plan pays 80% of allowable charges; if care received as an inpatient, also subject to the appropriate inpatient hospital copay
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 40% of allowable charges; plan pays 60% of allowable charges; if care received as an inpatient, also subject to the appropriate inpatient hospital copay

Transplants

Coverage is available *only* when organ, bone marrow and stem cell transplants meet the criteria for benefits and are done in a transplant center (the team of physicians that performs the transplant and the hospital in which it is done) with a Premera Blue Cross contract or is in the special network of transplant centers around the country, as follows:

- Benefits for transplant services are provided on the same basis as any other service, **up to a lifetime maximum of $250,000**, subject to the applicable copays, deductible and coinsurance. Copays for office visits during the 180-day post transplant period (see Recipient Costs, below) are waived.

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

1. The type of transplant must not be experimental or investigational (see "Definitions" for experimental/investigational). 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: In this plan, the term "transplant" does not include corneal transplants, skin grafts, or the transplant of blood or blood derivatives (except for hematopoietic stem cells). Coverage for these services may be provided under other benefits.
2. The medical condition must meet Premera Blue Cross established criteria.
3. 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 plan for at least 12 consecutive months before transplant benefits are payable unless:

1. The transplant is directly related to an injury which occurs on or after the date the recipient became covered under this plan, *or*
2. The transplant is directly related to a congenital anomaly of a dependent child who has been continuously covered under this plan since birth, *or*
3. An entire plan is eliminated or the entire group transfers to a WEA Select Medical plan. In such cases, employees *may* be eligible to have the time immediately preceding enrollment on a WEA Select Medical 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 as follows:

- 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 Medical plan will be provided in accordance with that agreement.

OR

- 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.

Plan benefits, limitations, exclusions and preauthorization requirements for recipient and donor costs are subject to the transplant benefits of the WEA Select Medical plan. Additionally, all services related to an organ transplant that is determined by Premera Blue Cross to be experimental and/or investigational or that occur during the first 12 months the enrollee is enrolled will not be covered. This includes services like 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:

- **Recipient Costs:** Inpatient and outpatient benefits for transplant or reinfusion related expenses start accruing to the $250,000 maximum one day before the date of a solid organ transplant, or in the case of bone marrow or stem cell procedures, one day before the date of reinfusion. For bone marrow transplants, covered services include any chemotherapy and radiation therapy that is part of the inpatient care covered by this benefit. Benefits stop accruing to the $250,000 maximum 180 days from the date of transplant or reinfusion. However, the time limits above don't apply to this benefit's coverage for transportation and lodging.
- **Donor Costs:** 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 plan 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 Premera Blue Cross.

Transportation and Lodging Expenses

Reasonable and necessary expenses for transportation, lodging and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided
- When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) are charged against the recipient's $250,000 maximum and are limited to $7,500 per transplant

Exclusions and limitations:

This benefit does not include:

- 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 investigational according to the criteria in "Definitions."
- Services or supplies 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 from it (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" and "Transportation and Lodging Expenses," above, and medically necessary "Ambulance Services" on page 22.
- Meals and lodging except as covered above under "Transportation and Lodging Expenses."
- 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 the "Prescription Drugs" benefit on page 15.

Please also see "What's Not Covered."

X-Ray, Radium and Radioactive Isotope Therapy (See Surgical and Medical Care)

WHAT'S NOT COVERED?

NON-COVERED SERVICES

Your plan 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 plan 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. Services or supplies provided by volunteers, except as specified in the "Home Health Care" benefit on page 25 and "Hospice Care" benefit on page 11.
7. Any service, supply or procedure which Premera Blue Cross determines is experimental or

investigational on the date it is furnished. Our determination is based on the criteria stated in "Definitions" for experimental/investigational." Also excluded are complications of such services or supplies.

If we determine that a service is experimental or investigational 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.

Note: This exclusion does not apply to certain experimental or investigational services provided as part of oncology clinical trials as determined by us.

8. Services, supplies or drugs for sex transformations.
9. Milieu therapy (treatment intended primarily to provide a change in environment or a controlled environment).
10. 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.
11. Charges from providers for records or reports, except those we request for utilization review.
12. Electronic, on-line or internet consultations or evaluations.

LIMITED SERVICES

Your plan 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 to:
   - Repair a defect caused by an injury if the services, supplies and procedures are rendered within 12 months of the injury
   - Treat functional disorders
   - Perform reconstructive breast surgery in connection with a mastectomy as provided under the "Mastectomy and Breast Reconstruction Services" benefit on page 28.
   - Repair a dependent child's congenital anomaly (see "Definitions")
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 13 and 27.
4. Vocational counseling; outreach; job training and other counseling or training services, except as stated under "Health Education" on page 25, and "Chemical Dependency Treatment" on page 23.
5. Services or supplies received in and billed by a non-participating hospital owned or operated by a county, state or federal agency, except:
   - For treatment of a medical emergency
   - 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, a convalescent home or anything similar, except as specifically covered by your plan.
7. Custodial care. This includes room, board, any other facility services and professional care provided for senile dementia, mental deficiency or retardation, or primarily to assist you with activities of daily living because of a physical or mental condition, or age. See "Definitions" section.
8. Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient facilities, or unless the enrollee's medical condition makes inpatient care medically necessary.
9. Transportation services and devices, except as stated under the "Transplants" benefit and medically necessary ambulance services as specified on page 22.
10. Routine physical 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 "Preventive Care" on page 19 and "Diagnostic Imaging and Laboratory Services" on page 24.

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 for them, except as specifically provided in "Prosthetics, Orthotics and Medical Equipment" on page 30.
12. Hearing examinations; hearing aid, new or replacement, except as specified in the "Audio (Hearing) Benefit" on page 10.
13. Hospital care for the extraction of teeth or other dental procedures, except as stated on page 24.
14. Services of a licensed dentist (D.M.D. or D.D.S.) or denturist except as specified on page 24; dental services such as extractions, prostheses (bite guards), 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 24.
15. Services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain-dysfunction (MPD), except as specified on pages 21 and 33.
16. Inpatient and outpatient rehabilitative care (including, but not limited to, speech, physical, massage and occupational therapy), except as specified under "Inpatient Rehabilitative Care" on page 28 or "Outpatient Rehabilitative Care" on page 14. 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 the plan.
17. Inpatient and outpatient neurodevelopmental therapy except as specified under "Inpatient Neurodevelopmental Therapy" on page 27 or "Outpatient Neurodevelopmental Therapy" on page 13.
18. Transplants, except as specified on page 33.
19. Treatment for alcohol or drug use, abuse or dependency except as defined and provided in "Chemical Dependency Treatment" on page 23.
20. Services, supplies, drugs and procedures for sexual disorders and dysfunction, whether the consequence of illness, disease or injury, including but not limited to impotence (except as specified), or frigidity.

    Services, supplies, drugs and procedures for fertility enhancement or assistance, infertility or diagnosis or treatment of reproductive disorders regardless of diagnosis or origin of condition. Benefits are not provided for any services, drugs or supplies related to assistive reproductive technology, including, but not limited to, sperm or egg harvesting, storage or banking; in vitro fertilization, artificial insemination, and gamete intrafallopian transplant, and any direct or indirect complications of such procedures. Also excluded is reversal of sterilization.
21. Well-baby care, including physical examinations except as specifically provided under "Preventive Care" on page 19 and under "Newborn Care" on page 28.
22. Any services or supplies not specifically listed as covered benefits.
23. Treatment of psychiatric conditions, including treatment of eating disorders such as anorexia nervosa, bulimia or any similar conditions except as specified on pages 12 and 20. Also excluded are residential treatment services.
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 are not covered.
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 confined in a medical facility, or prescription drugs covered under "Retail Pharmacy Drugs" on page 15, "Speciality Pharmacy" on page 16, "Mail Order Pharmacy Program" on page 15, "Home Health Care"

on page 25, "Hospice Care" on page 11, "Chemical Dependency Treatment" on page 23, or " Dietary Formula (PKU)" on page 25. Even if prescribed by a physician, this plan does not cover fertility drugs (regardless of their intended use); over-the-counter drugs and supplies; food supplements; herbal, naturopathic or homeopathic medicines or devices; and vitamins that do not require a prescription.

27. Home health care except as specified on page 25.
28. Hospice care except as specified on page 11.
29. Nicotine dependency or treatment of tobacco dependency or abuse, except as specified on page 12.
30. Nonsurgical treatment of obesity and morbid obesity, including drug therapy, except as specified on page 12. 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 plan 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.
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 investigational according to the criteria stated in "Definitions" for experimental/investigational.
32. Biofeedback Services
    - Biofeedback for psychiatric conditions other than generalized anxiety disorder
    - EEG biofeedback and neurofeedback

GENERAL PROVISIONS

CERTIFICATION OF NEED FOR HEALTH CARE SERVICES

We have the right to require proof of medical necessity from an enrollee receiving benefits under this plan. This proof may be submitted by you or on your behalf by providers. No benefits will be available under this plan 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 has 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 "What If I Have Other Coverage"), made to the enrollee, 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 plan must be filed:

- Within three years of the date we denied in writing the rights claimed under this plan 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 plan, 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

WHAT IF I HAVE OTHER COVERAGE?

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

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

Definitions

Plan means all of the following, even if they do not have their own coordination provisions:

- Group or blanket disability insurance or health care plans issued by insurers, health care services contractors and health maintenance organizations
- Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
- Government plans 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 plan. 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 plan.

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 plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided is considered an allowable expense.

Claim Determination Period means a calendar year.

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." This means they reduce their payment amounts so that the total benefits from all plans do not exceed the allowable expenses. We will coordinate benefits when you have other health care

coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed on the primary coverage.

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

1. A plan that does not provide for coordination of benefits
2. A plan which covers an enrollee as other than a dependent
3. A plan which covers an enrollee as a dependent. For dependent children, the following rules apply:
    - **When the Parents Are Not Separated or Divorced:** The plan 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 plans. Otherwise, the rule set forth in the plan which does not have this provision determines 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 plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who does not have custody.

If the rules above do not apply, the plan that has covered an enrollee for the longest time will be primary, except that benefits of a plan 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 plan 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 plans involved have this provision regarding laid-off or retired employees.

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

Any amount by which a secondary plan's benefits have been reduced as discussed in this section will be used by the secondary plan to pay the enrollee's unpaid allowable expenses. However, the enrollee must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims that were submitted up to that time during the claim determination period.

EFFECT OF MEDICARE

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

This plan also provides benefits as primary over Medicare to the extent that an employer-sponsored health care plan 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.

DUAL WEA COVERAGE

When an enrollee is covered under more than one WEA Select Medical plan (Plans 1, 2, 3, 4-500, 4-750 or 5), the following provisions apply:

1. Any required enrollee cost sharing (including deductibles, coinsurance and/or copays) is waived.
2. Instead of the stated percentages, benefits are provided at 100% 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.
4. Benefits with visit maximums are not doubled.

If a service or supply is excluded on one plan but covered on the other one, 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 above if it would result in a higher benefit payment.

SUBROGATION AND REIMBURSEMENT

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 will be subrogated to any rights that you may have to recover compensation or damages from that liable party related to the injury or illness, and we would be entitled to be repaid for payments we made on your behalf out of any recovery that you obtain from that liable party after you have been fully compensated for your loss. The liable party is also known as the "third party" because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss.

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 payments we have made on your behalf after you have been fully compensated for your loss. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. In recovering payments made on your behalf, we may at our election hire our own attorney to prosecute a subrogation claim for recovery of payments we have made on your behalf directly from third parties, or be represented by your attorney prosecuting a claim on your behalf. Our right to prosecute a subrogation claim against third-parties is not contingent upon whether or not you pursue the party at fault for any recovery. If you recover from a third party and we share in the recovery, we will pay our share of the legal expenses. Our share is that percentage of the legal expenses necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

Before 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. In the event of a trial or arbitration, you must make a claim against, or otherwise pursue recovery from third-party payments we have made on your behalf, and give us reasonable notice in advance of the trial or arbitration proceeding. You must also cooperate fully 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. If you fail to cooperate fully with us in the recovery of the payments we have paid on your behalf, you are responsible for reimbursing us for payments we have made on your behalf.

You agree, if requested, to hold in trust and execute a trust agreement in the full amount of payments we made on your behalf from any recovery you obtain from any third-party until such time as we have reached a final determination or settlement regarding the amount of your recovery that fully compensates you for your loss.

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

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION 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, personal injury protection (PIP) or similar type of insurance or contract.

WHO IS ELIGIBLE FOR COVERAGE, AND WHEN?

EMPLOYEE COVERAGE

You are eligible if you are a WEA member who works at least 17.5 hours a week in any division of the Washington Public Schools or the WEA and its Affiliates. If your participating employer group contributes toward the cost of the plan's coverage, the WEA membership and 17.5 hours per week requirements will be waived.

To remain eligible during a school year, a senior substitute teacher must stay in the substitute pool and remain classified 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.

Eligible employees must enroll within 30 days of their eligibility date or at the annual open enrollment period. Premera Blue Cross enrollment forms are available at the school district's business office. Complete and return it to the school district's business office.

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

Age 65/Continuing 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, the WEA Select Medical plan will provide primary coverage and Medicare coverage will be secondary.

DEPENDENT COVERAGE

Dependents have the same effective date as you (except if acquired after the effective date), provided you have made proper application. Eligible dependents are:

- The lawful spouse
- The unmarried children up to age 25 for whom the subscriber provides total or partial support. ("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.)
- An unmarried child age 25 or older incapable of self support due to a physical or developmental disability is 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.
    - You complete a Request for Certification of Handicapped Dependent form (call the WEA Service Team for the form.) We must approve the request for certification. If you are requesting continuation of coverage for a disabled child past age 25, you must provide the certification form to us within 31 days of the child reaching the limiting age. **An overage disabled child who is enrolling on the same date as you are also requires our approval.** You must provide proof of continuous group coverage for the disabled dependent. **Please Note:** You and the disabled child must maintain concurrent coverage under this plan.
    - You provide 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 25th birthday.

- A legally placed ward of you or your spouse permanently lives in your home.

Marriage

You must apply within 60 days of marriage to add a newly acquired spouse and children. 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, (spouse/child) may not enroll until the next open enrollment period. The only exception is explained under "Loss Of Other Coverage".

Natural Newborn Children

Children of you or your spouse born while you are covered under this plan are covered from date of birth if enrolled within 60 days of birth. They will receive the same medical benefits as other dependents, as well as benefits for prematurity and congenital defects. To enroll a newborn, please submit a Premera Blue Cross enrollment form to the school district's payroll office. If the subscription charges being paid on your behalf already include coverage for dependent children, a new enrollment application is not required. However, you must advise us of the desire to enroll the 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 are automatically covered for three weeks following the date of birth when the mother is enrolled on this plan 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 your 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 your behalf already include coverage for dependent children, a new enrollment application is not required. However, you must submit copies of the adoption documents within the 60-day period.

Please contact the WEA Select Service Team at 1-800-932-9221 for information on the appropriate documents needed by Premera Blue Cross for adding the 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 was awarded in accordance with the laws of the state in which it was 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 is either you or your spouse. The guardian/person with non-parental custody and the child must both be enrolled under the same plan.
- The child is under 25 years old and single.
- The child has been placed in your home under a parent-child relationship.
- The guardian/person with non-parental custody provides the main support for the child, outside of

federal or state support.

When a completed enrollment application is received for an eligible 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 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".

Medical Child Support Orders

When a child is to be added to your coverage due to a medical child support order, we must receive a copy of the court order (or National Medical Support Notice, Part A or Part B) with the completed enrollment application. When we receive these documents within 60 days of the date of notice, coverage for the eligible child required under the order becomes effective on your coverage as of the date of the notice.

If we do not receive these documents within the 60-day time period, coverage under your plan will be effective on the first of the month after we receive the order and application. The application may be submitted by you, 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 on the first billing cycle following the date of enrollment.

Surviving Dependents

If you die, the medical coverage under this plan will continue for enrolled surviving dependent(s) without a subscription charge for up to 12 months following your death. This coverage will only be provided for dependents who were enrolled under this plan at the time of your death and will be subject to the Coordination of Benefits provision stated in this benefit booklet. The school district's business or payroll office must be notified of this information within 30 days. This 12-month period will apply toward the 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 Eligible for Coverage 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 subscription charge waiver will no longer apply.

CHANGE IN DEPENDENT STATUS

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

Please report any changes immediately. You will be reimbursed for subscription charges for only 60 days prior to the date a change is reported to us. Premera Blue Cross will have the right to recover any benefits paid in error.

When a covered dependent is no longer eligible on your medical group coverage, he or she may continue health care coverage on a Premera Blue Cross group conversion plan or through COBRA, see "How Do I Continue Coverage?"

LOSS OF OTHER COVERAGE

You and your dependents may enroll on this plan outside the open enrollment period if you had other health care coverage at the time this plan was offered, but later lost it. The loss of the other coverage *must* be due to one of the following events:

- Loss of eligibility for coverage for reasons including, but not limited to legal separation, divorce, death, end of employment, retirement, a reduction in the number of hours employed, or reaching a non-WEA Select health care plan's overall lifetime benefit maximum
- The employer terminates its contribution toward the coverage, or
- You were covered under COBRA and that COBRA coverage on a non-WEA Select Plan has been

exhausted

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

We must receive the application and monthly payment within 60 days of the date the prior coverage ended. Coverage on the plan will begin on the first of the month after we receive the application.

Please also see "Plan Transfers".

ENROLLMENT PERIODS

In addition to the criteria described in sections above, the following enrollments may be available.

Open Enrollment

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

Eligible employees and/or dependents who are not enrolled on this medical plan or any other medical plan 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 " Special Enrollment."

Special Enrollment

You and your dependents may enroll on this plan outside the open enrollment period when *both* of the following requirements are met:

- 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 plan when it was offered during the open enrollment period

You may also choose to enroll without enrolling any eligible dependents. We must receive the 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 coverage begins depends upon the qualifying event. 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.

CONTINUED ENROLLMENT: SELF-PAY PROVISIONS

Leave Of Absence

Coverage for you and any enrolled dependents on an official leave of absence or sabbatical may continue 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 the leave of absence, you may not enroll on the plan until your return to active employment. If you do not elect coverage under the leave of absence provision, or terminate coverage during the leave, you will immediately become eligible for COBRA. To be eligible for COBRA, you must elect coverage under COBRA within 60 days after coverage ends under the leave of absence provision.

A district-approved leave beyond 18 months does not entitle you (or your enrolled dependents) to extend coverage under this leave of absence provision. If the 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 COBRA (see below). If you do not return to work after the leave or if another consecutive district-approved leave is granted without another period of active employment, 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 coverage.

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

Example:

- You are granted a leave of absence and are no longer actively at work as of March 20
- Your active work results in fringe benefit dollars for March, which pay for April benefits
- You will receive sick leave through the district leave-sharing plan for two 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 you notice of access to COBRA continuation for 18 additional months (total 36 months). If the above leave of absence started before the March payroll cutoff for benefits, the leave period would begin April 1.

Dependents may not be added while you are 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 the school district's payroll office for additional information.

Labor Dispute

If compensation is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may pay subscription charges for yourself and eligible dependents directly to the employer for up to six months. See "How Do I Continue Coverage?" and "Converting To A Different Plan" 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 the plan.

When your compensation or wage is suspended or terminated, you will be notified immediately in writing by your participating employer group. A notice will be mailed to the address last on record with your participating employer group that you may pay subscription charges to the participating employer group as noted in this section.

Reduction In Force (for employer groups with less than 20 employees)

For those participating employer groups who do not provide COBRA this plan may be continued on a self-paid basis through the group for up to 12 months from the date of lay-off.

HOW DO I CONTINUE COVERAGE?

Continuation Under USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

COBRA Continuation Of Group Coverage (for participating employer groups with 20 or more employees)

When group coverage is lost because of a "qualifying event" outlined below, federal laws and regulations require the participating employer group to offer an election to continue the group coverage for a limited time. (These laws and regulations are referred to in this plan 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 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.
- 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. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

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

You Must Give Notice Of Some Qualifying Events

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

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

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

- For determinations of disability, the notice period starts on the **later** of: 1) the date of your termination or reduction in hours; 2) the date qualified enrollee would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please note: Determinations that a qualified enrollee is disabled must be given to the group before the 18-month continuation period ends. This means that the subscriber or qualified enrollee might not have the full 60 days in which to give the notice.** Please include a copy of the determination with your notice to the group.

  Note: You or your affected dependent must also notify the group if a qualified enrollee is deemed by the Social Security Administration to no longer be disabled. See "When COBRA Coverage Ends."
- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified enrollee would lose coverage as a result of the event.

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

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

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

You Must Enroll And Pay On Time

- The enrollee must elect continued coverage no more than 60 days after the **later** of: 1) the date coverage was to end because of the qualifying event, or 2) the date the participating employer group notified the enrollee of his or her right to elect continued coverage.

  Each qualified enrollee will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.
- The enrollee must send the first subscription charge payment to the participating employer group no more than 45 days after the date the person elected continued coverage.
- 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.

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under "Special Enrollment" or "Open Enrollment" in the "When Does Coverage Begin" section. With one exception, family members added after COBRA begins aren't eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under "Qualifying Events And Lengths Of Coverage" earlier in this COBRA section. The exception is that a child born to or placed

for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep the participating employer group informed of address changes

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

When 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:

- The applicable continuation period expires.
- The next monthly subscription charge is not paid when due or within the grace period.
- If the enrollee has extended COBRA coverage due to disability, it will end if Social Security determines that the person is 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 the enrollee is not disabled, coverage would end May 31. The enrollee must provide the participating employer group a copy of the determination within 30 days after the **later** of: 1) date of the determination or 2) the date on which you or your affected dependent was informed that this notice should be provided and given procedures to follow.
- The enrollee becomes covered under another group health care plan after the date COBRA coverage was elected. If, however, the new plan contains an exclusion or limitation for a pre-existing condition, coverage does not end for this reason until the exclusion or limitation no longer applies.
- The enrollee becomes entitled to Medicare after the date COBRA coverage was elected.
- The participating employer group ceases to offer this WEA Select Medical plan to any employee in the bargaining unit/employee classification. However, the enrollee should contact the participating employer group regarding participation in any other group health plan offered to the bargaining unit/employee classification.

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

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the group. For more information about your rights under federal laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

Converting To A Different Plan

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

- **Individual plan** You may wish to consider applying for enrollment under one of the Premera Blue Cross individual medical plans (available to persons under age 65).
- **Conversion plan** You may be entitled to coverage under one of our conversion plans. Conversion plans are individual plans that differ from this one. You pay the monthly payment. You must apply and send the first subscription charge payment to us within 31 days of the date coverage ends under this plan.

  You may apply for a conversion plan if you live in Washington State are not eligible for Medicare coverage, and one of two things is true:

  - You are not entitled to services or benefits for medical and hospital care under another group

plan.

- You are entitled to other coverage, but that coverage contains exclusions or waiting periods for any pre-existing conditions.

  For more information about our conversion plans, contact your participating employer group or the WEA Select Service Team.

  Please Note: The rates, coverage and eligibility requirements of our conversion plans differ from those of this group plan. In addition, enrollment in a conversion plan may limit the enrollee's ability to later purchase an individual plan without a pre-existing condition waiting period.

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, some people *may* be eligible for guaranteed-issue coverage under certain Medicare supplement plans if they apply within 63 days of losing coverage under this plan.

These plans' subscription charges and benefits may differ from this medical plan. For specific information, contact Premera Blue Cross.

When You Retire

The above options are available as stated under "Converting To A Different Plan." Plans are also available to school district retirees through the Public Employees Benefits Board (PEBB), administered by the Washington Health Care Authority (HCA). Call 1-800-200-1004 for eligibility information for PEBB sponsored plans.

WHEN WILL MY COVERAGE END?

RIGHTS TO BENEFITS AFTER TERMINATION

Benefits are not provided for services, treatment, medical attention or care that an enrollee received after his or her coverage terminated or the contract terminated.

No rights are vested under this plan.

EVENTS THAT END COVERAGE

Coverage for the subscriber and all dependents under this medical plan 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 plan
  - 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:

- The 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 plan. (See "Coverage For Surviving Dependents")

Dependent Child(ren):

- Reaches the age of 25 (unless developmentally disabled or physically handicapped - See "Dependent Coverage")

- Marries
- The subscriber dies or is no longer covered under this plan. (See "Coverage For Surviving Dependents")

If the subscriber is no longer employed by or eligible for coverage with the participating employer group or a family member is no longer eligible, medical coverage will be cancelled automatically without notice at the end of the period for which subscription charges have been appropriately paid. **Refunds will not exceed more than 60 days worth of subscription charges, based on the date a change is reported to us**. See "How Do I Continue Coverage? COBRA" and "Converting To A Different Plan" for continued health care benefits.

CERTIFICATE OF PRIOR GROUP HEALTH COVERAGE

When coverage through the participating employer group's health plan terminates, including COBRA, the enrollee will receive a "Certificate of Group Health Coverage." The certificate will provide information regarding coverage under the participating employer group's health plan. When the person provides a copy of the certificate to a new health plan, he or she may receive credit toward any pre-existing condition waiting period. The enrollee will need a certificate each time he or she leaves a health plan and enrolls in a plan with a pre-existing condition waiting period. Therefore, it is important to keep the certificate in a safe place. If the enrollee has not received a certificate, or has misplaced it, the enrollee has the right to request one from us or the former employer within 24 months of the date coverage terminated.

When the enrollee receives the Certificate of Group Health Coverage, he or she should make sure the information is correct. Contact us or the former employer if any of the information listed is not accurate.

Documents that may establish creditable coverage in the absence of a certificate include explanations of benefit claims or correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

Please note that when someone transfers 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 "Transplants" on page 33 for additional information.

PLAN TRANSFERS

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

When someone transfers from one WEA Select plan to another, amounts credited toward applicable calendar year deductibles, coinsurance maximum or benefit maximums under the other plan will also apply to this one's applicable coinsurance, benefit and lifetime maximums. Annual benefit maximums met in one calendar year will not be credited to a subsequent calendar year.

HMO Option: Employees who have elected coverage through an HMO offered by the participating employer group may change coverage and enroll under this plan only during an open enrollment period which is approved by Premera Blue Cross, or if they move outside of the HMO service area.

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

WHAT IF I HAVE A QUESTION OR WANT TO APPEAL A CLAIM DECISION?

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 plan.

Toll-Free: 1-800-932-9221
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 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 no more than 30 calendar days.

WHEN YOU HAVE APREMERA BLUE CROSS 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, WA 98111-9202

PREMERA BLUE CROSS 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 investigational 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. An extension to the 60-day limit may be granted in the event the enrollee needs to obtain additional medical documentation, physician consultations or opinions, if the enrollee is hospitalized or traveling, or for other reasonable cause beyond the enrollee's control. In no case will the extension exceed 180 days.

Level II: Your appeal will be reviewed by a Premera 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 five 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.

WEA CLAIM APPEAL PROCESS

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 plan's benefits, limitations and exclusions, how to obtain care, and how to appeal our decisions.

You may also ask for the following information:

- Your right to seek and pay for care outside of your plan
- 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 plan'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 at www.premera.com/wea or call the WEA Select Service Team at:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

DEFINITIONS

Below are terms used in this benefit booklet.

Allowable Charge The allowable charge means 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, copays, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this plan.

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

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

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

- 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 deductibles, coinsurance, copays, 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.

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 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 plan. This date is established by, and appears on the records of, Premera 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 plan.

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

Experimental/Investigational Services Experimental or investigational 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 booklet. 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 A 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, injury, or condition harmful or threatening to the enrollee's life or health, unless provided for preventive services when specified as covered under this plan.
- 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.

Oncology Clinical Trials Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An "oncology clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
- Any drug or device provided as part of a phase I oncology clinical trial
- Services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage.
- Services provided in a clinical trial that are fully funded by another source

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage **before** you enroll in the clinical trial.

Orthodontia 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 plan. For further details, please refer to the appropriate sections of this plan booklet or call the WEA Select Service Team at:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

Subscriber The employee who is eligible for the benefits of this medical care plan. 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.

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

TERM 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

TERM LIFE 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:

a. 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

b. enrolled under the Washington Education Association Select Medical Plan.

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 Medical Plan provided you have completed:

a. a full day of Active Work on that date; or

b. 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 Medical Plan), 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 Medical Plan, or (2) the end of the following month, unless your coverage terminates earlier as described above.

The Washington Education Association reserves the right to terminate, suspend, withdraw, amend or modify the Plan at any time. Any such change or termination in benefits (i) will be based solely on the decision of the Washington Education Association and (ii) may apply to active employees, future retirees and current retirees as either separate groups or as one group.

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

Accelerated Death Benefit (herein called Living Benefit Option)

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 as shown on the next page.
2. Terminally III 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.

Seat Belt Benefit - If the Employee suffers a covered loss as a result of an automobile accident while wearing a seat belt, an additional AD&D benefit of 10% of the Principal Sum, not to exceed $10,000, will be paid.

Exposure and Disappearance Benefit - If as a result of a covered accident, the Employee is unavoidably exposed to the elements and suffers a Loss for which a benefit is otherwise payable, such Loss will be covered. If the body of the Employee has not been found within one year of a disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the Employee was traveling, then the Loss of Life benefit will be paid.

Education Benefit - If the Employee dies as a result of an accident for which an AD&D benefit is paid, an extra benefit of 10% of the Principal Sum, not to exceed $5,000 will be paid to each Qualified Student. Benefits are payable annually for a maximum of four consecutive years. Qualified Student means a Spouse or Child who at the time of the Employee's death, is a full-time post-high school student in a school of higher learning. A 12th-grade student will be deemed a Qualified student if he or she becomes a student within 12 months of Employee's death.

Felonious Assault Benefit - If the Employee as a result of a criminal act, suffers a covered Loss while working for the employer, an additional benefit equal to 50% of the AD&D benefit will be payable.

Speech and Hearing Benefit - If the Employee as a result of a covered accident, suffers total and irrecoverable loss of speech and total deafness in both ears, the benefit payable will be 100% of the Principal Sum. For the loss of speech or hearing, the benefit payable will be 50% of the Principal Sum.

Paralysis Benefit - If the Employee as a result of a covered accident, suffers quadriplegia (both upper and lower limbs), paraplegia (both lower limbs) or hemiplegia (upper and lower limbs, one side) the benefit payable will be 100% of the Principal Sum.

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 AND APPEAL PROCEDURES

How To File A Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in your group insurance certificate. The Provident must receive a completed claim form. The form must be completed by you, or your authorized representative, your attending physician and your Employer. If you or your authorized representative have any questions about what to do, you or your authorized representative should contact the Provident directly.

CLAIMS PROCEDURES

If A Claim Is Based On Death Or A Covered Loss Not Based On Disability

In the event that your claim is denied, either in full or in part, the Provident will notify you in writing within 90 days after your claim was filed. Under special circumstances, The Provident is allowed an additional period of not more than 90 days (180 in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from the Provident indicating the reason for the delay and the date you may expect a final decision. The Provident's notice of denial shall include:

- the specific reason or reasons for denial with reference to those plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring suit in federal court.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If A Claim Is Based On Your Disability

The Provident will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if the Provident both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which the Provident expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the Provident may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If An Appeal Is Based On Death Or A Covered Loss Not Based On Disability

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive the Provident's notice of denial. You, or your authorized representative has (have) the right to:

- submit a request for review, in writing, to the Provident;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records, and other information relating to the claim to the Provident.

The Provident will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Schedule of Insurance provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring civil suit under federal law.

Notices of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If An Appeal Is Based On Your Disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If the Provident determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). The Provident will notify you in writing if an additional 45-day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the Provident may decide your appeal without that information.

You will have the opportunity to submit written comments, documents or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by the Provident and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, the Provident will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, the Provident will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a civil suit under federal law;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that compiles with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

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, Inc.
1420 Fifth Ave, Suite 1200
Seattle, Washington 98101-4030
(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

Reference: Provident Entity 9060, W-138, Plan 2

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WEA
WASHINGTON
EDUCATION
ASSOCIATION

MEDICAL BENEFITS UNDERWRITTEN BY:

PREMERA | BLUE CROSS

WEA SELECT SERVICE TEAM
7001 220th Street S.W.
Mountlake Terrace, WA 98043-2124
Toll Free 1-800-932-9221
Hearing Impaired Toll Free TDD 1-800-842-5357

LIFE INSURANCE UNDERWRITTEN BY:

UNUM

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

WEA PLAN CONSULTANT:

AON

Employee Benefits Consulting
1420 Fifth Ave., Suite 1200
Seattle, WA 98101-4030
(206) 467-4646

www.premera.com/wea

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