



***Health & Welfare Benefits
Booklet***

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This brochure is a description of the benefits available under your plan with NoaNet arranged through the Public Utility Risk Management Services (PURMS) Self-Insurance Fund and Administered by Pacific Underwriters.

INTRODUCTION

NoaNet offers an excellent benefit package covering a broad range of services for injury and illness.

This plan provides coverage for employees and dependents enrolled with NoaNet.

The plan allows you a wide choice of network providers through the First Choice Health Network who have agreed to accept the “reasonable amount” as payment for services to employees.

In this brochure, NoaNet is referred to as the “Company”, First Choice Health Network is referred to as the “Network”, Pacific Underwriters is referred to as the “Administrator” and the PURMS Self-Insurance Fund is referred to as the “Fund”.

The PURMS Self-Insurance Agreement has several terms and conditions which may affect the procedures outlined in this booklet. A copy of the agreement is available at the Company or Administrator’s office.

DEFINITIONS

Reasonable Amount: An expense is reasonable if, in the Administrator’s judgment, the charge is the usual and customary charge for that attention or care in the locale where it is received. If the Administrator cannot determine the usual and customary charge for the attention or care because there are not enough providers of that attention or care in the locale to establish a prevailing charge, the Administrator will calculate the reasonable charge for it based on:

- the complexity of the attention or care; and
- the degree of professional skill needed to provide it; and
- other pertinent factors.

Any amount a Non-Network Provider charges for Medical Care that is more than the Administrator consider reasonable as defined above, is not a Covered Expense.

Approved Provider: Means one of the following:

- **Out of Area Provider:** A provider outside the network area acting within the scope of that provider’s license, who belongs to a category of providers whose services or supplies would be covered under this plan as benefits if furnished inside the network area. The out-of-area provider must have the qualifications and license or certification equivalent to the qualifications and license or certification required for the comparable provider category inside the network area. Outside Washington, an approved home health agency or hospice agency must be certified as such by Medicare.

- **Network Provider:** A provider whose name is included in the current list of network providers for this plan as prepared by the Network and provided to the group and who has entered into a current participating agreement with the Network
- **Non-Network Provider:** A provider whose name is not included in the current list of network providers for this plan as prepared by the Network and provided to the group and who has not entered into a current participating agreement with the Network

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

Copay: The amount, in addition to the rate, which you are required to pay for certain services and supplies provided under this plan. You are responsible for the payment of any copay directly to the provider of the service or supply.

Custodial Care: Care that, as determined by the Administrator, is designed primarily to assist you in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of ordinarily self-administered.

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

Medical Emergency: The sudden and unexpected onset of a condition or exacerbation of an existing condition requiring medically necessary care to safeguard your life or limb immediately after the onset of the emergency, as determined by the Administrator. For the purpose of benefit determination, consideration will be given by the Administrator to the symptoms of the condition and to the actions that would have been taken by a prudent person under such circumstances.

Medically Necessary: A service or supply that meets all of the following criteria as determined by the Administrator.

- It is required to diagnose or treat your condition.
- It is consistent with the symptoms or diagnosis and treatment of the condition.
- It is the most appropriate supply or level of service that is essential to your needs.
- When applied to an inpatient, it cannot safely be provided on an outpatient basis, including diagnostic studies.
- It is not an investigational service or supply.
- It is not primarily for the convenience of you or your provider.

The fact that a service or supply is furnished, prescribed, recommended or approved by a physician or other provider does not, of itself, make it medically necessary. A service or supply may be medically necessary in part only.

Negotiated fee: The amount that a Preferred Provider Organization (PPO) health care provider has agreed to charge for a service, treatment or supply provided to a covered person.

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

Practitioner: In compliance with statutory requirements, the benefits of this plan are also provided for licensed chiropractors and licensed optometrists acting within the scope of their licenses.

Network Area: The geographic area designated by the Network as its participating network area. Since the Network is continuing to expand the network area, please check with the Administrator's office for up-to-date information.

Stoploss: The dollar limit of coinsurance amounts that you are responsible to pay during a calendar year: after you have reached this limit, the Company will pay most benefits at 100% of the reasonable amount for the remainder of the calendar year. Some benefits are not subject to the stoploss provision as specified in the Benefits section: these benefits will always remain payable at the percentage level given in the Summary of Benefits or in the applicable benefit section. **In addition, the following do not count towards the stoploss: your annual deductible; any copays; the difference between the reasonable amount and the provider's actual charge; and any balances that remain after benefit limits have been expended.**

Temporomandibular Joint Disorder: A disorder that has one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

SUMMARY OF BENEFITS

This is a brief summary of benefits. More information is given in this brochure. To receive any benefits under this plan, you must satisfy any deductible, copay or waiting period requirements. Additional benefits may in some cases be available and will be described in the Benefits section of this brochure. All benefits may be subject to specific limitations and maximums and are subject to your lifetime maximum. Please read the entire brochure for details on these and other benefits.

LIFETIME MAXIMUM \$1,000,000.

ANNUAL DEDUCTIBLE \$75 per person; \$225 per family, per calendar year.

BENEFIT SCHEDULE

- Network physicians' services paid at 100% of the reasonable amount.
- Licensed alternative providers services paid at 100% of the reasonable amount
- Generic-brand prescription drugs paid at 100% including oral contraceptives

The following benefits will be paid at 85% of the reasonable amount until your eligible out-of-pocket expenses have reached \$300 per person, per calendar year; then paid at 100% of the reasonable amount:

- Semiprivate room and board
- Other hospital and skilled nursing facility services
- Name-brand prescription drugs including oral contraceptives
- Home medical equipment
- Ambulance services

- Other special benefits

Chemical dependency treatment paid at 100% of the reasonable amount to \$5,000 every two calendar years, to a lifetime maximum of \$10,000.

Hearing aids paid at 85% of the reasonable amount to \$2,000 every three years (not subject to the deductible or stoploss).

\$25 copay for each visit to a hospital emergency room for illness, injury or surgery (waived if directly admitted to the hospital as an inpatient).

Inpatient mental disorder treatment is paid at 80% of the reasonable amount to 15 days per calendar year; outpatient mental disorder treatment is paid at 50% of the reasonable amount to 25 visits per calendar year.

One routine physical examination paid at 100% of the reasonable amount per calendar year.

Smoking cessation benefit provided at 75% of the reasonable amount to a lifetime maximum of \$500.

Treatment for temporomandibular joint disorders (TMJ) provided at 50% to a lifetime maximum of \$3,000.

Vision care benefits are not subject to the deductible.

Ambulance Services	85%
Ambulatory Surgical Center	85%
Alternative Provider Benefit – Network	100%
Alternative Provider Benefit – Non-Network	85%
Chemical Dependency Treatment	100%
Chiropractic Services	100%
Hearing Aid benefit	85%
Home Health and Hospice Care	90%
Home Medical Equipment	85%
Infusion Therapy	90%
Neurodevelopmental Therapy	85%
Professional Services – Network	100%
Professional Services – Non-Network	85%
Prostheses and Orthotics	85%
Rehabilitative Care – Inpatient	
Physician	100%
Facility	85%
Rehabilitative Care – Outpatient	100%
Skilled Nursing Facility Services	85%
Smoking Cessation Programs	75%
Transplant Benefit	100%

WHEN AM I ELIGIBLE FOR COVERAGE?

EMPLOYEE ELIGIBILITY

Active and designated contract employees of the group who work a minimum of 20 hours per week are eligible for coverage under this plan. Elected officials are considered full-time employees. Coverage begins the first of the next month after your date of employment unless your date of employment is the first date of the month in which case coverage begins on the date of employment.

DEPENDENT ELIGIBILITY

Eligible dependents include:

- The employee's husband or wife.
- A natural child, adopted child, stepchild, judicially appointed minor ward of the employee or a child legally placed for adoption and primarily dependent on the employee, spouse, or non-covered legal parent for support. A child legally placed for adoption includes a child for whom the employee has assumed a total or partial legal obligation for support in anticipating of adoption. In addition, a child of the employee will be eligible for coverage under this plan when required by a court order. A dependent must be unmarried and under age 25 to be eligible for coverage under this plan.
- Children who are incapacitated due to developmental disability or physical handicap and chiefly dependent upon the employee, spouse, or non-covered legal parent for support and maintenance are also eligible for benefits, provided the dependent was covered immediately prior to the 25th birthday and the incapacity occurred prior to the 25th birthday. Benefits will be provided for the duration of the incapacity unless coverage terminates. Proof of the incapacity and dependency shall be submitted to the Company not more frequently than one time per year following the child's 25th birthday.

APPLICATION FOR COVERAGE

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

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

If you declined enrollment in writing, for you or your dependents, due to other coverage, you may apply for coverage under this plan, prior to the next anniversary date if the Company receives your application for coverage within 30 days of exhaustion of COBRA continuation coverage, or loss of the prior health coverage. Coverage will begin on the first day of the month after the Company has accepted the application. If you acquire a dependent either through adoption, placement for adoption, birth of a child, or marriage, you and your dependents may apply for coverage prior to the next anniversary date. The company must receive your application within 31 days of marriage, or within 60 days of birth, placement for adoption, or date of assumption of total or partial legal obligation for support of a child, in anticipation of retroactive coverage, to either the date of birth of a natural newborn, the date of placement of an adoptive child, the date of assumption of total or partial legal obligation for

support of a child in anticipation of adoption, or in the case of marriage, on the first day of the month after the Company has accepted the application.

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

NEWBORN AND ADOPTED CHILDREN

For the employee's natural newborn child, coverage will be retroactive to the date of birth provided the Company receives the employee's application for the new dependent's coverage within 60 days following birth. For the employee's adopted child, coverage will be retroactive to the date of placement for adoption or the date the employees assumed total or partial legal obligation for the child's support in anticipation of adoption if the Company receives the employee's application for the new dependent's coverage within 60 days following placement, or following the employee's assumption of legal obligation for the child's support. For the employee's natural newborn, adoptive child under age 18, or child placed for adoption under age 18, none of the preexisting limitations or preexisting waiting periods of this plan, if any, will apply to such child if enrolled for coverage under this plan with 60 days of birth, adoption, or placement for adoption. If your group's contract does not require a rate payment for the natural newborn or adoptive child, you do not have to complete an application for the child. However, for both newborns and adopted children, the company should receive applications within 31 days to prevent delays in claims processing.

HOSPITALIZATION ON EFFECTIVE DATE

If you or your dependent is confined to a hospital or other facility when coverage would normally begin, coverage will not begin until after discharge, except for adoptive children and newborn children of employees and spouses covered under this plan as provided by law (including the "Erin act"), if the employee applies for coverage as specified above.

WHAT DO I DO WHEN I NEED CARE?

Network Providers: When receiving treatment from a network provider, be sure to present your identification card. At the time of service you should inform your provider about copays that are required on your plan. Arrangements for paying copays should be handled directly between you and your provider.

Non-Network Providers: In the network area, you may also use the services of a Non-Network Provider, as defined in the Definitions section. Benefits for Non-Network Providers will be paid at the percentage stated in the Benefits section and will be based on the reasonable amount.

The services of a practitioner, as defined in the Definitions section, will also be covered up to the amount paid to a network provider as shown in the Summary of Benefits.

Emergency Care: In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a network provider. Benefits will be based on the Non-Network Provider's actual charge for the service where those charges are reasonable and are not increased on the basis of the coverage of this plan. Please refer to the Definitions section for the definition of a medical emergency.

OUTSIDE THE NETWORK AREA

Outside the network area, benefits will be provided for care received from an out-of-area provider based on the reasonable amount at the level specified for network providers.

Be sure to present your identification card when consulting a provider or receiving treatment at a hospital.

See page 24 on claims submission.

RELEASE OF MEDICAL INFORMATION

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

- Any provider to disclose to the Administrator any medical information it requests.
- The Administrator to examine your medical records at the offices of any provider.
- The Administrator to release to or obtain from any person or organization any information necessary to administer your benefits.
- The Administrator to examine your employment records in order to verify your eligibility.

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

COST CONTAINMENT PROVISIONS

Your plan includes a health management program to encourage you to be aware of and involved in decisions about the most cost-effective level of medical care that is appropriate for you. There are frequently less costly alternatives to more expensive medical procedures or settings. Please read the cost containment provisions carefully. If you do not follow the procedures, your benefits could be significantly reduced. Benefits for these procedures are subject to waiting periods, if any, the annual deductible and all other provisions of this plan as described in this brochure.

VOLUNTARY SECOND SURGICAL OPTION

If you choose to have a voluntary second surgical opinion before having surgery, the physician's services and any related x-ray and laboratory charges will be paid in full for the second opinion and are not subject to any deductible or copay.

If you are using an out-of-area physician and request a second surgical opinion, you must have the physician contact the Administrator at the number listed in the Customer Service Directory in order to receive full benefits for the second surgical opinion.

If you do not follow the procedures for obtaining a second surgical option, benefits will be paid at the Professional Services payment level, and will be subject to any deductible or copays of your plan.

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

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

MAXIMUM BENEFIT

The benefits of this plan are limited to a \$1,000,000 lifetime maximum per covered person. This maximum applies to all combined benefits provided under this and any prior Company plans. In addition on January 1 of each calendar year the amount charged against your lifetime maximum will be reduced by \$20,000.

THE DEDUCTIBLE

The deductible is a cost of **covered** medical expenses that you must incur and are responsible to pay before your benefits are available. The deductible for this plan is \$75 per covered person, per calendar year. No benefits will be provided until the deductible has been met. The reasonable amount for any benefits provided by this plan can be applied to your deductible; however, any copays required by your plan will not apply to your deductible.

\$225 Family Deductible: If three or more covered family members incur eligible deductible expenses totally \$225 in a calendar year, no further deductible will be required from any family member during that calendar year.

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

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

Hospital Outpatient Department Deductible: In addition to the annual deductible described above, you will be required to pay \$25 copay for each emergency room visit when you are not directly admitted to the hospital as an inpatient.

How to Submit Proof of Your Deductible: As you incur deductible expenses, your provider should bill the Administrator direct. If direct billing is not possible, submit your Claim as specified in the How Do I File a Claim? on page 24. You will receive itemized statements showing what amounts have been credited toward your deductible.

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

BENEFITS

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

All covered benefits are subject to the **limitations, exclusions and provisions** of this plan. You must be under the care of an approved provider. Benefits are identical for employees and dependents, except where otherwise specified.

If you or your provider has any questions regarding coverage, please call the appropriate phone number listed in the Customer Service Directory.

The benefits of this plan will be provided at the indicated percentages of the reasonable amounts until your out-of-pocket coinsurance percentages (called your stop loss limit) have reached \$300 per person, per calendar year. Once your stop loss limit has been reached, this plan will provide benefits at 100% of the reasonable amount for the remainder of the calendar year for all benefits unless otherwise specified.

Professional Services: Office, Home, Hospital and Skilled Nursing Facility Visits – 100%:

The services of an approved provider who is not a facility that provides inpatient services will be provided for injury and illness, including x-ray, laboratory, surgery, second opinions for surgery and injectable drugs for covered conditions, and for covered services for women's health such as gynecological care and general examinations as medically appropriate and medically appropriate follow-up visits. Injectable drugs, including antigen and allergy vaccine will also be provided.

Alternative Provider Benefit – 100%: Benefits are provided for the services listed below for an approved provider, per calendar year. Services will be provided within the approved provider's scope of license and practice. The calendar year deductible will apply.

- Acupuncture services provided by a licensed acupuncturist to relieve pain, induce surgical anesthesia, and for other therapeutic purposes.
- Naturopathic services provided by a licensed naturopathic physician for treatment of a covered illness, injury or condition, including but not limited to: manual manipulation, physical modalities, homeopathy, minor office procedures, common diagnostic procedures consistent with naturopathic practice, and radiographs ordered by the physician.
- When prescribed by your physician, nutritional counseling and education services directly related to medically necessary treatment of a covered illness, injury or condition when provided by a licensed dietitian/nutritionist.
- External manipulation or pressure of soft tissue for therapeutic purposes (massage therapy) provided by a licensed massage practitioner for treatment of a covered illness, injury or condition.

Please Note: Benefits for chiropractic services are not available under the Alternative Provider Benefit: refer to the "Chiropractic Services" section on page 21 for a description of these benefits.

Preadmission Testing For Surgery: Approved Physician and Hospital Charges – 100%

Services of an approved physician and an approved hospital will be provided for outpatient preadmission testing for surgery at the hospital where you will be confined, if you are admitted within 48 hours after testing begins.

Hospital Services – 85%: Inpatient and outpatient services at an approved hospital will be provided for injury and illness (including services of staff physicians billed by the hospital). Room and board limited to the hospital's average semiprivate room rate. You will be responsible to pay a \$25 copay for each hospital emergency room visit for illness, injury or surgery (waived if directly admitted to the hospital as an inpatient). The copay will not apply for surgery in hospital's outpatient or ambulatory surgical center. This copay cannot be used to satisfy your annual deductible specified on page 10, nor will not accumulate toward your stop loss limit.

Preventive Care Benefit – 100%: Services will be provided for one routine physical examination per calendar year. This benefit is not subject to the deductible. Mammograms and preventive injections or immunizations are included.

Well Child Care – 100%: Well-child examinations for the covered child to a maximum of six within the first year of child's birth, two during the child's second year, annually from the third through sixth years, and once each 24-month period thereafter. This benefit is not subject to the deductible.

Name-Brand Prescription Drugs – 85%/Generic Prescription Drugs – 100%: Name-brand and generic drugs will be paid based on the percentage of the reasonable amount. Drugs requiring a prescription by federal or state law will be provided when dispensed by a licensed pharmacist to treat a condition covered under this plan, limited to a 34-day supply or 100 units per purchase, whichever is greater. Insulin dispensed by a physician or certified laboratory will also be provided. Antigen and allergy vaccine are provided under the physicians' services benefit of this plan. Any other drugs or medications furnished by the physician or any drugs not requiring a prescription will not be provided.

Ambulance Services – 85%: The services of an approved ground ambulance company will be provided if other transportation would endanger your health and the purpose of the transportation is not for personal or convenience reasons. Benefits for licensed air ambulance service will be provided to the nearest hospital equipped to render the necessary treatment, upon review and approval of the Administrator.

Ambulatory Surgical Center Services and Supplies – 85%: The services of an approved ambulatory surgical center will be provided for injury or illness.

Blood Bank – 85%: The services of a recognized blood bank will be provided.

Diabetes Care Training – 85%: The outpatient benefits of this plan will be provided for diabetic self-management training and education, including nutritional therapy, if recommended by an approved provider with expertise in diabetes.

Home Health Benefit – 90%:

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

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

- You must be homebound, which means that leaving the home could be harmful, involves a considerable and taxing effort and you are unable to use transportation without the assistance of another.
- Your condition must be serious enough to require confinement in a hospital or skilled nursing facility in the absence of home health services.

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

- Nursing services by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).

- Physical therapy services by a licensed physical therapist.
- Speech therapy services by a speech therapist certified by the American Speech and Hearing Association.
- Occupational therapy services by an occupational therapist certified by the American Occupational Therapy Association.
- Medical social services by a person with a master's degree in social work.
- Home Health aide services by an aide who is provided part-time or intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Respiratory therapy services by an inhalation therapist certified by the National board of Respiratory Therapists.
- Medical supplies dispensed by the home health agency that would have been provided on an inpatient basis.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding, subject to the infusion therapy benefit limit of this plan.

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

Limitations and Exclusions: Home health benefits are limited to a maximum of 130 visits per calendar year.

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

Any expenses for home care that qualify both under this benefit and under any other benefit of this plan will be covered only under the benefit the Administrator determines to be the most appropriate.

No benefits will be provided for the following:

- Services normally provided for under a hospice program.
- Services to other family members.
- Services of volunteers, household members, family or friends.
- Food, clothing, housing or transportation. (See the ambulance benefit of this plan.)
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.
- Homemaking or housekeeping services, except as specifically provided under the home health aide benefit.
- Financial or legal counseling services.
- Custodial or maintenance care.
- Hourly care services.
- Services or supplies not specifically set forth as a covered benefit, or limited or excluded under the regular limitations and exclusions of this plan.

Home Medical Equipment – 85%: Home medical equipment rented or purchased (if approved by the Administrator) from an approved home medical equipment company will be provided for therapeutic use. Such equipment includes crutches, wheelchair, kidney dialysis equipment, standard hospital beds, equipment for the administration of oxygen, and medically necessary diabetic equipment, such as blood glucose monitors, insulin infusion devices and insulin pumps. To be covered, equipment must meet certain criteria established by the Administrator. Equipment ordered before your effective date of coverage will not be provided. Equipment ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of home medical equipment due to normal use or growth of a child will be provided. “Home medical equipment” means the equipment can withstand repeated use; its only function is for treatment of the medical condition, or it contributes to the improvement of function related to the condition and is generally not useful in the absence of the condition; and it is appropriate for home use. Equipment whose primary purpose is preventing illness or injury, items primarily designed to assist a person caring for the patient, and items generally useful in the absence of the condition will not be covered. No benefits will be provided for items such as, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, corrective shoes, heating pads, enuresis (bed wetting) training equipment, hearing aids, exercise equipment, weights, whirlpool baths, keyboard communication devices, adjustable beds, orthopedic chairs or personal hygiene items. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. The Administrator may elect to provide benefits for a less costly alternative item.

Home Phototherapy – 100%: Services and supplies furnished by an approved home Phototherapy provider will be provided for newborn hyperbilirubemia (newborn jaundice).

Hospice Benefit – 90%

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

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

- Nursing services by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).
- Physical therapy services by a licensed physical therapist.
- Speech therapy services by a speech therapist certified by the American Speech and Hearing Association.
- Occupational therapy services by an occupational therapist certified by the American Occupational Therapy Association.
- Medical social services by a person with a master’s degree in social work.
- Home health aide services by an aide who is providing part-time or intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Respiratory therapy services by an inhalation therapist certified by the National board of Respiratory Therapists.

- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by internal feeding, subject to the infusion therapy benefit limit of this plan.
- Respite care for a minimum of four or more hours per day (continuous care of the patient to provide temporary relief to family members or friends from the duties of caring for the patient.)

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

Covered Inpatient Services: When you are confined as an inpatient in an approved hospice that is not an approved hospital or a skilled nursing facility, the same benefits that are available in your home will be available to you as an inpatient. In addition, a semiprivate room allowance will be provided. The services must be provided by employees of and billed by the hospice. This inpatient hospice benefit will be limited to 14 days during the six-month benefit period. For services in a hospital or a skilled nursing facility, see the hospital and skilled nursing facility benefits of this plan.

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

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

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

No benefits will be provided for the following:

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

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

Infusion Therapy Benefit – 90%: Services and supplies will be provided for infusion therapy furnished by an approved infusion therapy provider to a maximum of \$25,000 per calendar year under this infusion therapy benefit and the home health and hospice benefits of this plan combined. Drugs and supplies used in conjunction with infusion therapy will be provided only under this infusion therapy benefit. Benefits will also be provided for growth hormone when furnished by an approved infusion therapy provider for growth hormone deficiency in children. Turner’s syndrome, growth failure in children secondary to chronic renal insufficiency, prior to renal transplant, or for the promotion of wound healing in patients with severe acute burns. Growth hormone treatment of these listed conditions is covered when authorized by Administrator in advance. No other benefits for infusion therapy will be provided under this plan.

Prostheses and Orthotics – 85%: Benefits will be provided for the purchase of braces, splints, orthopedic appliances and other orthotic supplies and for purchase of a prosthesis for functional reasons when replacing a missing body part when obtained from an approved prosthetic and orthotic supply provider. No benefits provided for cosmetic prostheses except for necessary external and internal breast prostheses following a mastectomy. External breast prostheses are limited to one replacement every three calendar years. An item ordered before your effective date of coverage will not be provided. An item ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of an item due to normal use or growth of a child will be provided. The Administrator may elect to provide benefits for a less costly alternative item. For other special equipment, see the Special Equipment and Supplies benefit below.

Skilled Nursing Facility – 85%: Inpatient services and supplies of an approved skilled nursing facility will be provided for illness, accidental injury or physical disability. Room and board limited to the facility’s average semiprivate room rate. Your approved physician must submit for approval by the Administrator and periodically review a written treatment plan specifically describing the services to be provided. No custodial care is provided.

Special equipment and Supplies – 85%: The following will be provided at 85% of the reasonable amount: casts; colostomy bags and related supplies; catheters; surgical appliances; syringes and needles for insulin and allergy injection; dressings medically necessary for wounds, cancer, burns or ulcers; and oxygen. Formulas for the treatment of phenylketonuria will be provided at 100% of the reasonable amount and will not be subject to any waiting periods described in the Limitations section, if any. Items ordered before your effective date of coverage will not be provided. Items ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of items due to normal use or growth of a child will be provided.

Chemical Dependency Treatment Facility – 100%: The services and supplies of an approved chemical dependency treatment facility will be provided for medically necessary inpatient and outpatient treatment for chemical dependency, including detoxification, supportive services and prescription drugs prescribed by the facility, provided to a maximum of \$5,000 every two calendar years. Chemical dependency means addiction to or abuse of alcohol, drugs or any other chemical substance. Benefits will be limited to a combined lifetime maximum of \$10,000 under this and any other Company plan or any other group-sponsored plan. Any chemical dependency

benefits provided during the previous 24-month period under this or any prior Company plan or plan with another carrier will be charged against the two-year benefit limit.

Whenever reasonably possible, prenotification of treatment must be submitted at least 10 days before treatment begins. No chemical dependency treatment benefits will be provided for information and referral services, information schools, Alcoholics Anonymous and similar chemical dependency program, long-term care or custodial care, tobacco cessation programs and emergency service patrol. No other benefits for chemical dependency treatment are provided under this plan.

Hospitalization for Dentistry: An approved physician and hospital benefits will be provided to an inpatient when medically necessary. No benefits provided for charges of a dentist; for administration of or cost of anesthesia; for hospitalization for myofascial pain syndrome or any related appliances; for hospitalization for malocclusion or other abnormalities of the jaw, except as specifically provided under the TMJ benefit.

Hearing Aid Benefit: Benefits for examination, hearing aid, ear molds(s), and repairs are provided at 85% to \$2,000 every three calendar years. Hearing aid expenses that exceed the \$2,000 limit are not covered under this plan.

The following expenses are not covered:

- Charges for hearing aids that do not meet professionally accepted standards of practice, including charges for any services or supplies that are experimental in nature.
- Replacement of hearing aids that are lost, broken or stolen unless the replacement occurs after the three-year period described above.

All other expenses incurred in connection with hearing aids not specifically mentioned are not covered under this hearing aid benefit.

Hearing aid benefits are not subject to the deductible or stoploss.

Injury to teeth: The services of a licensed dentist or denturist will be provide at 100% of the reasonable amount only for repair of accidental injury to sound, natural teeth. Injuries caused by biting or chewing are not covered. Treatment must begin within 30 days of the accident and all services must be provided within 12 months of the date of the injury. The services of a licensed denturist will also be provided when the service would be covered if provided by a licensed dentist (D.M.D. or D.D.S.). A licensed denturist means a person licensed as a denturist under RCW chapter 18 and acting within the scope of his or her license. Payment will be based on the reasonable amount, any additional charges will be the patient's responsibility. You must be continuously covered by this or a prior company plan from the date of the injury.

Maternity Benefits: Medical services including prenatal and postnatal treatment of pregnancy, normal or cesarean delivery, and voluntary termination of pregnancy shall be treated the same as any other illness or injury and are provided for the female employee or the male employee's wife for services incurred while she is covered by this plan. Covered inpatient and postpartum services will be provided when ordered by the

Attending provider in consultation with the female employee or the male employee's wife. Maternity benefits also include coverage for false labor. Maternity benefits are not subject to the preexisting condition waiting periods described in the When Won't Things Be Covered? Section,

if any. These maternity benefits are not available for dependent daughters, provided the same as any other illness or injury. Complications of pregnancy include, but are not limited to, diabetes if onset is after conception, fetal distress, and toxemia. Complications do not include charges for false labor or charges in connection with a normal pregnancy, cesarean section, or voluntary termination of pregnancy, except for any complications that may arise. See the What Else Do I Need to Know? on page 24.

Neurodevelopmental Therapy Services – 85%: The benefits described below will be provided for medically necessary neurodevelopmental therapy treatment to restore and improve function for children age six and under. In addition, this benefit includes maintenance services where significant deterioration of the patient’s condition would result without the service. Benefits will be provided as follows:

- The services of an approved provider for physical and speech therapy only, or a recognized occupational therapist for occupational therapy only will be provided in the office, home or hospital outpatient department.
- Regular inpatient hospital and skilled nursing facility benefit will be provided for an inpatient neurodevelopmental therapy admission when care cannot safely be provided on an outpatient basis. Hospital services must be provided in a hospital approved by the Administrator for rehabilitative care.
- Your participating physician must submit for advance approval by the Administrator and must periodically review a written treatment plan specifically describing the neurodevelopmental therapy services to be provided.
- Benefits will be paid at 85% of the reasonable amount to \$2,000 per calendar year for all neurodevelopmental therapy services combined. You will not be eligible For both the Rehabilitative Services benefit and this benefit for the same condition. (Not subject to the stoploss provision.)
- No benefits will be provided for custodial care; maintenance (except as specified above). Nonmedical self-help, recreational, educational or vocational therapy; mental disorder care; chemical dependency rehabilitative treatment; gym or swim therapy.

Newborn Infants: The professional and hospital benefits of this plan will be provided for routine care for a newborn infant while hospitalized during the first 72 hours following birth, not described in the “When Am I Eligible for Coverage:” section of this brochure. The regular benefits of this plan will be provided for illness, injury or physical disability, including congenital anomalies, for the newborn only if any required application for coverage is received as specified in the “When Am I Eligible for Coverage?” section of this brochure.

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

Rehabilitative Services: The benefits described below will be provided for rehabilitative care when medically necessary to restore and improve function previously normal but lost due to illness or injury. Benefits will also be provided for treatment of congenital anomalies for a newborn child covered from birth. Benefits will be provided as follows:

- Regular inpatient hospital and skilled nursing facility benefits will be provided for an inpatient rehabilitative admission for physical, speech and occupational therapy, to a maximum of \$50,000 per condition. You must be continuously covered under this or a prior

medical plan with the Company from the onset of the condition. Hospital services must be provided in a hospital approved by the Administrator for rehabilitative services. Treatment must occur within three calendar years from the date of your first hospital or skilled nursing facility rehabilitative care admission while covered under a medical plan with the Company.

- Physical or speech therapy in the office, home or hospital outpatient department will be paid at 100% to the allowed amount to \$2,000 per calendar year. Services must be provided by an approved provider for physical and speech therapy only. The initial claim must be submitted with the physician's prescription for the rehabilitative services.
- If you had an inpatient rehabilitative admission for the condition and did not exhaust your \$50,000 inpatient benefit, you may apply to the Administrator for additional outpatient benefits beyond the \$2,000 limit. Limited extension may be granted up the balance of the unused inpatient benefit if the Administrator determines the services to be medically necessary.
- No benefits will be provided for custodial care; maintenance, nonmedical self-help, recreational, educational or vocational therapy; mental disorder care; learning disabilities or developmental delay; chemical dependency rehabilitative treatment; guy or swim therapy.

Smoking Cessation Benefit – 75%: The services of an approved physician, approved psychologist or approved smoking cessation provider will be provided for a smoking cessation program at 75% of the reasonable amount to a lifetime maximum of \$500. To receive benefits for smoking cessation, you must complete the full course of treatment. No benefits will be provided for inpatient services; vitamins, minerals and other supplements; over-the-counter drugs or prescription drugs prescribed by your covered provider to ease nicotine withdrawal; books or tapes; or hypnotherapy unless performed by an approved provider. No other benefits for smoking cessation will be provided under this plan. (Not subject to the stoploss provision.)

Sterilization Procedures: Benefits will be provided for sterilization procedures, subject to the waiting periods described in the “When Won’t Things Be Covered?” section on page 21. Reversals of these procedures will not be covered.

Temporomandibular Joint Disorders (TMJ) – 50%: Benefits will be provided for medical services furnished by an approved physician, approved hospital, or approved physical therapist for treatment of temporomandibular joint disorders. This benefit will be limited to 50 percent of the reasonable amount to a lifetime maximum of \$3000.

“Medical services” for the purpose of the TMJ benefit mean those services that are: 1) reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and 2) effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint; pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and 3) recognized as effective, according to investigational or primarily for cosmetic purposes. All services must be provided or ordered by your approved physician and are subject to the waiting periods described in the “When Won’t Things Be Covered?” section of this brochure on page 21. Benefits for all surgical services related to TMJ must be authorized by the Administrator in writing, in advance. The Administrator will waive its advance notification requirements for treatment commencing within 48 hours, or as soon as is reasonably possible as determined by the Administrator, after

the occurrence of an accidental injury or trauma to the temporomandibular joint. No other benefits for TMJ will be provided under this plan. (Your percentage share for treatment will not accumulate toward your stoploss amount).

Transplant Benefit: The benefits of this plan will be provided for all medically necessary services or supplies relating to all transplants as follows, as determined by the Administrator:

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

- Heart
- Heart/lung (combined)
- Kidney
- Kidney/pancreas (combined)
- Lungs – single/bilateral/lobar
- Liver
- Cornea
- Bone marrow or other forms of stem cell rescue (only covered for certain conditions – see contract)
- Small Bowel
- Small Bowel/liver

Benefits for all transplants must be authorized by the Administrator in writing, in advance. Any transplant must be provided by a facility approved by the Administrator. If a transplant is not successful, one retransplant will be covered, subject to the benefit limits specified.

Donor Organ Benefits: Donor organ procurement costs will be covered to a maximum of \$25,000 per transplant if the recipient is covered for the transplant under this plan. See the contract for details. Donor benefits will be charged against the recipient benefit limits.

Travel Expenses: Travel and lodging expenses for you and your family will be covered when you are required by the Administrator to travel 100 miles or more outside the network area for medically necessary services related to an approved transplant. Benefits will be paid at the level specified for participating hospitals to a maximum of \$2,500 per transplant episode requiring travel and must be approved in advance by the Administrator.

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

- Nonhuman, artificial or mechanical transplants.
- When the recipient is not covered under this plan.
- Investigational procedures.
- Services in a facility not approved by the Administrator.
- Donor and procurement costs incurred outside the United States unless approved by the Administrator.
- Living donor transplants (except kidney or bone marrow).
- Stem cell rescue, autologous bone marrow transplants and chemotherapy associated with autologous stem cell rescue or autologous bone marrow transplants, except as specified in the contract.

You will not be eligible for any benefits related to a transplant until the first day of the thirteenth month of continuous coverage under this plan, whether or not the condition is preexisting or an emergency.

Mental Disorder Treatment: Benefits will be paid at 80% of the reasonable amount for mental disorder treatment when you are confined as an inpatient in an approved hospital, a state mental hospital as defined in RCW 72.23.010, or a licensed community mental health agency that has an inpatient facility, limited to 15 days per calendar year.

Benefits will also be provided for mental disorder treatment when you are not confined as an inpatient paid at 50% of the reasonable amount to 25 visits per calendar year for the services of an approved physician, an approved psychologist, an approved MSW, an approved mental health counselor, an approved marriage and family therapist (however, marriage and family counseling will not be covered) or a licensed community mental health agency. No other benefits for treatment of mental disorders will be provided under this plan. (Not subject to the stoploss provisions.)

Chiropractic Services – 100%: Will be provided for 10 spinal adjustments by hand per year when performed by a licensed chiropractor. Benefits will be paid at the level specified for professional services as described in the Summary of Benefits section.

VISION CARE BENEFIT

Hardware – Frames every 24 months and lenses every 12 months will be provided at 100% when prescribed by an approved provider to correct a refractive error (not subject to the stoploss provision). These providers include approved physicians, approved optometrists and approved optical providers. You can take advantage of specially negotiated prices from approved optical providers. Lenses include single vision, bifocal, trifocal, lenticular, aphakic lenses (external lenses requiring a frame and contact lens) and contact lenses (including daily wear). This benefit is limited to either lenses or contacts, but not both.

Eye Examinations – In addition to the vision care benefits shown above, you will receive one routine eye examination each calendar year to determine the need for a new or changed prescription for corrective lenses; paid at 100% of the reasonable amount when performed by an approved physician, an approved optometrist or an approved optical provider.

Vision care benefits are not subject to the deductible or copay requirements.

WHEN WON'T THINGS BE COVERED?

WAITING PERIODS

TRANSPLANT WAITING PERIODS

You will not be eligible for any benefits related to a transplant, including stem cell rescue, bone marrow transplants, and chemotherapy associated with stem cell rescue or bone marrow transplants until the first day of the thirteenth month of continuous coverage under this plan, whether or not the condition is preexisting or an emergency.

BENEFIT PORTABILITY

Eligibility: To be eligible for the following waiting period provisions, you must have had creditable coverage, as defined below, at any time during the three-month period immediately preceding the date of application for coverage under this plan. Coverage under the immediately preceding plan must have ended when coverage under this plan began. However, if your group requires you to complete a probationary period before your coverage under this plan becomes effective, your date of hire will be counted as the first day of coverage in determining whether you had coverage at any time during the three months as described above. Any time accrued under the probationary period will be credited toward the satisfaction of the preexisting condition waiting periods of this plan.

“Creditable coverage” means immediately preceding health coverage, Medicare, Medicaid, CHAMPUS, FEHBP, the Indian Health service, a state health benefits risk pool, Peace Corps plan, or other public health plan. The following prior coverage types are not creditable coverage; accident only, disability income, and combinations thereof; supplement to liability insurance, liability, both general and automobile; worker’s compensation, automobile medical; credit only; on-site medical clinics, or similar coverage where medical care is secondary or incidental to other insurance benefits; dental only, vision only, long-term care, nursing home care, home health care, community-based care, and any combinations thereof, or other similar limited benefits, if offered separately; coverage for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, if offered independently or as noncoordinated coverage; Medicare supplement, coverage supplemental to coverage provided under chapter 55 of Title 10, U.S. Code, or similar supplemental coverage provided to coverage under a group health plan, if offered as a separate insurance policy.

Waiting Periods and Credits for Preexisting Conditions: You will not be eligible for benefits for preexisting conditions until you have been covered under this medical plan for three consecutive months, except maternity benefits, if any, do not apply to this paragraph. However, you will be allowed to credit the amount of time you were continuously covered under your immediately preceding health plan against the preexisting condition waiting period of this plan; if you were continuously covered for at least three months under the immediately preceding health plan, you will not be required to satisfy the waiting period for preexisting conditions under this plan.

A preexisting condition means a condition for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage under this plan.

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

LIMITATIONS AND EXCLUSION

No benefits are provided for the following, unless specifically stated otherwise below or unless specifically provided for in the Benefits section.

- Services and supplies not medically necessary (as defined in the Definitions section) for treatment of an illness or injury, unless otherwise listed as covered.

- Addiction to or abuse of drugs, alcohol or any other chemical substance whether legal or illegal, except as specifically provided in the Chemical Dependency Treatment Facility Benefit in the Benefits section.
- Benefits that are covered, or would be covered in the absence of this plan, by Medicare, or any federal, state or government program, and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid.
- Benefits payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance when such contract or insurance is issued to or makes benefits available to the patient, whether or not application is made for such benefits. Reimbursement to the Fund will be made without reduction for any attorney's fees incurred, except as specified in the contract.
- Charges that are above the provider's reasonable amount as defined in the Definitions section, except for medical emergencies.
- Charges that in the absence of this plan there would be no obligation to pay; services provided by a family member.
- Chiropractor services and spinal adjustments by hand except as specifically provided in the Chiropractic Services Benefit in the Benefits section.
- Conditions related to military service or war.
- Cosmetic surgery, except that benefits will be provided: 1) when related to an illness or injury occurring while covered under this plan; 2) for reconstructive breast surgery necessary because of a mastectomy; 3) for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast; and 4) for congenital anomalies.
- Custodial care.
- Dentistry, and dental x-rays, hospitalization for dentistry, except as specifically provided in the Benefits section.
- Equipment, supplies, prostheses, appliances, braces, or foot care appliances, except as specifically provided in the Home Medical Equipment, Prostheses and Orthotics, and Special Equipment and Supplies Benefits in the Benefits Section.
- Hospitalizations for minor conditions such as common colds and removal of small tumors.
- Injuries related to semiprofessional or professional athletics, including practice.
- Intentionally self-inflicted injuries; or injuries or illnesses self-inflicted or sustained in the following circumstances: 1) suicide or attempted suicide; 2) while engaged in any activity that results in a felony conviction; 3) while performing any acts of violence or physical force that would not be performed by a reasonably prudent person in similar circumstances; or 4) caused by an intentional overdose of a legal prescription or over-the-counter drug or an illegal drug or other chemical substance. (Being under the influence of a chemical substance will not be considered to affect the person's ability to form intent.)
- Investigational services or supplies, as specified in the contract.
- In-vitro fertilization, artificial insemination, embryo transfer, fertility drugs (such as Clomid, Pergonal or Serophene) or any other artificial means of conception. However, a pregnancy resulting from such conception will be covered under the regular benefits of this plan, as applicable.
- Neurodevelopmental therapy, except as specifically provided in the Neurodevelopmental Therapy Services Benefit in the benefits section.

- Nursing services, except as specifically provided in the Home Health Benefit and hospice Benefit in the Benefits section. Private duty nursing or hourly nursing charges not covered.
- Occupational injury or disease (including any arising out of self-employment) or any complications thereof if the patient is covered under state industrial insurance, workers' compensation, or any federal act.
- Rehabilitative care, except as specifically provided in the Rehabilitative Services Benefit in the Benefits section.
- Services provided by the group or any of its employees or agents.
- Stem cell rescue, bone marrow transplants, and chemotherapy associated with stem cell rescue or bone marrow transplants will be provided only under the Transplant Benefit in the Benefits section. No other benefits related to stem cell rescue, bone marrow transplants, and chemotherapy associated with stem cell rescue or bone marrow transplants will be provided under this plan.
- Surgery or treatment for sexual dysfunction or transsexualism
- Surgery, treatment, programs or supplies intended to result in weight reduction, regardless of diagnosis.
- Treatment for temporomandibular joint disorders, malocclusions or other abnormalities of the jaw, except as specifically provided in the Temporomandibular Joint Disorder Benefit in the Benefits section.
- Mental disorder treatment, except as specifically provided in the Mental disorder Treatment Benefit in the Benefits section.
- Mental disorder treatment for anorexia nervosa, bulimia or other eating disorders, except as specifically provided in the Mental Disorder Treatment Benefit in the benefits section.
- Drugs (except that inpatient benefits are provided for drugs in a hospital or skilled nursing facility). Preventive injections or immunizations will be covered only if provided in the Preventive Care Benefit in the Benefits section. FDA approved drugs used for off-label indications will be provided only if recognized as effective for treatment 1) in one of the standard reference compendia: 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia: or 3) by the federal Secretary of Health and Human Services. No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.
- Vision care, except as specifically provided in the Vision Care Benefit in the benefits section.
- Visual analysis, therapy or training; orthoptics.

HOW DO I FILE A CLAIM?

NETWORK PROVIDER SERVICES

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

NON-NETWORK PROVIDER SERVICES

When a provider or hospital does not bill the Administrator directly, you must submit your own claims. In that situation, be sure to request two copies of the itemized bill and submit the following information to the Administrator;

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

All claims must be submitted within 15 months of the date of service. However, if your coverage under this contract terminates, all claims must be submitted within six months of the date of termination. Claims not submitted within this time limit will not be paid.

WHAT ELSE DO I NEED TO KNOW?

FUND'S RIGHT TO RECOVER PAYMENTS

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

COORDINATION OF BENEFITS

(Coverage under another group or individual plan)

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

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

If the other plan does not contain a coordination of benefits provision, that plan will pay first. This plan will then pay the remainder of covered expenses. If the other plan contains a coordination of benefits provision, the following rules will determine payment:

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

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

BENEFITS AVAILABLE WHEN COVERAGE TERMINATES

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible for a special extension of group coverage when you are no longer eligible under this plan. If you elect a COBRA continuation of coverage, you will not be entitled to the Disability Extension explained below.

Disability Extension

If you or any covered family member is totally disabled due to a condition covered under this plan at the time coverage would normally terminate, the benefits of this plan will continue for treatment of the condition causing the disability for a maximum of 12 months, until benefits are exhausted or until you are enrolled under either a group plan with the Company or a plan through another carrier, whichever occurs first. To receive this extension of benefits, you must apply to the Company within 30 days of the time coverage would otherwise terminate. Proof of disability will be required.

Maternity Extension

If a female employee or male employee's wife is pregnant when coverage terminates, she will be eligible for the maternity benefits of this plan until 14 days following termination of pregnancy. Waiting periods described in the Limitations section will apply. If she is totally disabled when coverage would otherwise normally terminate, she will be eligible for the disability extension of benefits described above. No benefits will be provided for the newborn under this provision.

PAYMENT OF RATES DURING A LABOR DISPUTE

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

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

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

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

EXTENSION OF GROUP COVERAGE – COBRA

You may continue your group coverage past the point it would normally terminate as follows:

- Up to 18 months for you and your covered dependents from the date your employment terminates (except for gross misconduct), or the date you lose eligibility due to a reduction in hours. This includes but is not limited to a leave of absence or a labor dispute. However, coverage will be extended for up to 29 months for you or your covered dependent who is disabled according to the Social Security Act at the time of the initial COBRA qualifying event. Special notification requirements apply.
- Up to 36 months for your covered dependents from the date of the employee's death, divorce or legal separation, or the date a dependent child ceases to meet the eligibility requirements of this plan.
- If you are entitled to Medicare, you are not eligible for the COBRA provisions. If you are an active employee and elect Medicare as primary, your covered dependents may stay on the plan. When you cease to be an active employee, your covered dependents may apply for a COBRA extension. If a COBRA-covered employee becomes entitled to Medicare after COBRA coverage begins, the spouse or dependent child who is covered under the plan's COBRA extension may continue the COBRA extension for an additional 36 months from the date the employee became entitled to Medicare.
- If you are covered under another group health care plan when initially eligible for the COBRA extension, or if you become covered under another group health plan after your

COBRA continuation begins, you will not be eligible for COBRA continuation unless the other plan limits or excludes coverage for a preexisting condition you have. In such a case, you will not be eligible for COBRA continuation once that preexisting condition is covered.

- If timely notice of the qualifying event and your COBRA election rights are given as provided by COBRA, you will have 60 days from the date of the COBRA election notice or from the date coverage would terminate during which you may elect COBRA continuation coverage under this plan. Your group must notify the Company of your election will constitute a waiver of your rights to COBRA continuation coverage under this plan. Failure to provide timely notices may not, in all cases, terminate your right to continuation coverage; however, such failure will eliminate any obligation of the Company to provide continuation coverage under this plan.

This continuation of coverage provision will be subject to the COBRA law and regulations. If there is any conflict between these provisions and COBRA, the minimum requirements of COBRA will govern.

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

You or your dependents may be responsible for payment of the Company rates during an extension of coverage. Payment must continue to be submitted through your Company Representative. The right to an extension of coverage will end when your Company's coverage with the Fund terminates.

WHEN YOU ARE NO LONGER ELIGIBLE FOR COVERAGE

Federal law and certain states require continuation of coverage if your coverage terminates under certain circumstances. These continuation provisions should be explained to you at the time of your termination.

DENTAL BENEFITS

INTRODUCTION

This dental plan covers the following dental services for you and your covered family members.

- 100% of preventive and diagnostic services, such as examinations and x-rays.
- 100% of basic services, such as fillings and extractions.
- 50% of other services, such as crowns, bridges, onlays, dentures and partials.

This plan also covers the dental services described above when provided by a licensed dentist (D.M.D. or D.D.S.) or licensed denturist. Licensed dentist means a licensed doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.). Licensed denturist means a denturist licensed under RCW Chapter 18 who is acting within the scope of his or her license. However, payment of benefits is based on the appropriate percentage of the reasonable amount.

Reasonable amount means for a service, the amount determined by the Administrator to be the appropriate payment pursuant to any applicable agreement between the Network and a participating dentist or denturist. If no agreement exists between the Network and the dentist, the reason-

able amount means the lesser of either billed charges or the maximum allowable fee established by the Network.

You will be responsible for the balance of the charges that are not paid by this plan.

Eligibility: The eligibility provision of this plan are the same as those of your health care plan.

Maximum Benefit: This dental plan will provide the services listed in the summary of benefits to a maximum of \$2,000 per calendar year for each covered person.

Hospitalization for Dentistry: If you are hospitalized as an inpatient for dentistry and your participating physician certifies that hospitalization is necessary to safeguard your health, the hospital benefits of your health care plan will be provided. No benefits provided for hospitalization; for myofascial pain syndrome and any related appliances; or for malocclusions or other abnormalities of the jaw, unless specifically provided in your health care plan for TMJ benefits.

SUMMARY OF BENEFITS

Preventive and Diagnostic Services: This plan pays 100% of the reasonable amount for the following services:

- Oral examinations—limited to two examinations per calendar year.
- Dental x-rays. (A complete series of intra-oral films and panoramic films is limited to once every calendar year.)
- Prophylaxis (cleaning, scaling and polishing)—limited to two treatments per calendar year (including periodontal maintenance).
- Topical application of fluoride for persons under age 20.
- Oral hygiene instruction—limited to three sessions per lifetime.
- Plastic sealants for permanent teeth.
- Space maintainers for premature loss of primary teeth.

Basic Services: This plan pays 100% of the reasonable amount of the following services:

- Amalgam and composite restorations. (Composite covered only on teeth anterior to the first molar. Otherwise, amalgam allowances will apply.)
- Extractions for oral surgery.
- General anesthesia for oral surgery only (Local anesthesia included in allowance for procedure.)
- Endodontics, including direct pulp capping, pulpotomy and root canal therapy.
- Apicoectomy and root resections.
- Repair or relining of dentures.
- Recementing onlays or crowns.
- Repair of recementing of bridges
- Oral surgery, including treatment of fractures, dislocations, root recovery, alveoplasty, replantation, removal of odontogenic cyst and incision and drainage of abscesses.
- Tissue condition—limited to three treatments.
- Periodontal procedures, including:
 - Examination.
 - Scaling and root planing.
 - Occlusal adjustment.

- Gingivectomy and gingivoplasty (gum surgery).
- Gingival curettage (scraping of gums).
- Osseous (bone) surgery.
- Mucogingivoplastic surgery.
- Periodontal benefits are limited to treatment guidelines that have been developed by dental experts. A copy of the guidelines is available upon request.

Other Services: This plan pays 50% of the reasonable amount for the following:

- Gold onlay.
- Plastic, porcelain, stainless steel, nonprecious metal, semiprecious metal or gold crown. (Porcelain crowns covered only on teeth anterior to first molar. Otherwise, the metal allowance is provided.)
- Temporary prosthetics—for replacement of anterior teeth extracted less than one month prior only. (No other temporary prosthetics provided.)
- Buildup, pins, post, cast post and coping.
- Prosthetics, including bridges, dentures or partials.
- Temporary crowns—for immediate out-of-area emergency treatment only. (No other temporary crowns provided.)

Temporomandibular Joint Disorders: The benefits of this plan will be provided for dental services furnished for treatment of temporomandibular joint disorders as specified in the Definitions section of your brochure. Benefits will be limited to a combined maximum of \$1,000 per calendar year under this plan and the medical benefits of your plan with the Company, not to exceed a lifetime maximum of \$5,000 under medical and dental benefits combined. In addition, benefits for dental services under this paragraph will apply to the overall dental maximum under this plan. “Dental services” for the purpose of this temporomandibular joint disorder benefit mean those services that are:

1) reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and 2) effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint; pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and 3) recognized as effective, according to the professional standards of good dental practice; and 4) not investigational or primarily for cosmetic purpose. All services must be provided or ordered by your attending dentist. Benefits for all surgical services related to temporomandibular joint disorder must be authorized by the Administrator in writing in advance, except for treatment commencing within 48 hours, or as soon as is reasonably possible as determined by the Administrator, after the occurrence of an accidental injury or trauma to the temporomandibular joint. No other benefits will be provided for temporomandibular joint disorder under this plan.

Orthodontia Benefits: Orthodontic services by an orthodontist will be provided at 50% of the reasonable amount up to \$2,000 lifetime maximum. Treatment includes diagnosis, active treatment and retention treatment necessary to reduce or eliminate an existing malocclusion through the correction of malposed teeth. Extraction and x-rays connected with orthodontic treatment will be provided subject to the above limitation. NO benefits will be provided for the repair or replacement of any appliances. No benefits will be paid for prior to rendering treatment.

LIMITATIONS

- If a service or supply is not specifically stated in the summary, the Administrator will determine the benefit, if any.
- Benefits will be provided for the least costly procedure when optional techniques of treatment are available.
- Onlays and crowns are provided only if a tooth cannot be restored adequately with amalgam or a composite filling material. Otherwise, amalgam allowance is provided.
- Endodontics, crowns, bridges, and other service or prosthetic devices are provided only if treatment began on or after your effective date of coverage under this dental plan.

The benefits listed above for prosthetics are provided only:

1. For the initial installation, only if you were covered under this plan at the time of the extraction.
2. For replacement only if:
 - a. Additional teeth were extracted after initial installation and you were covered under this plan at the time of such extraction.
 - b. The existing denture, bridgework, onlay or crown was installed at least five calendar years prior to its replacement and cannot be made serviceable
 - c. The existing denture has been provided only as an immediate temporary denture and replacement by a permanent denture is required.

EXCLUSIONS

No benefits will be provided for the following:

- Appliances or restorations for the purpose of increasing vertical dimension or restoring occlusion.
- Charges as a result of injuries related to semi-professional or professional athletic contests, including practice.
- Charges for any service in excess of the percentages and maximums listed in the Summary of Benefits of this plan.
- Charges from any person other than a licensed dentist or licensed denturist, except for a licensed hygienist.
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements.
- Charges that would have been made or that you would have had no obligation to pay in the absence of this plan.
- Cosmetic dentistry or surgery, or unnecessary treatment.
- Endodontics, bridges, crowns, or other service or prosthetic devices requiring multiple treatment dates or fitting is treatment was started or ordered prior to your effective date under this plan or if the item was installed or delivered more than 30 days after your coverage terminates.
- Extraction of permanent teeth for tooth guidance procedures; procedures for tooth movement, regardless of purpose; correction of malocclusion, preventive orthodontic

procedures and other orthodontic treatment, unless specifically stated in the Summary of Benefits of this plan.

- Gold foil and inlay restorations. Amalgam allowances will be provide for these procedures.
- Materials not approved by the American Dental Association.
- Occlusal guards, except as provided in the Summary of Benefits of this plan.
- Prescription drugs, medications, or supplies.
- Provisional splinting.
- Replacement of lost or stolen items.
- Services to the extent that they are not necessary for treatment of a dental injury or disease or are not recommended and approved by the licensed dentist attending you: charges above the reasonable amount as determined by the Administrator; charges for failure to keep scheduled appointments or for filling out claim form.
- Study and diagnostic models
- Services for temporomandibular joint disorder except as provided in the Summary Benefits of this plan.

GENERAL INFORMATION

HOW TO FILE A DENTAL CLAIM

In most cases, filing of claims is not necessary; your dentist will handle this. The Administrator will notify you of any changes that you are responsible for, such as deductibles, coinsurance amounts or noncovered services. If your dentist will not file the claim, please refer to the claim filing procedures on page 24.

GENERAL PROVISIONS

- Certain provisions of your health care plan, including eligibility, limitations and exclusion (where applicable), review of rejected claim, coordination of benefits and first and third party payments will also apply to this dental plan.
- If a service or supply is not specifically stated in the summary, the Administrator will determine the benefit, if any.
- Benefits will be provided for the least costly procedure when optional techniques of treatment are available.

APPEAL OF A CLAIM DENIAL – ALL CLAIMS

The complete Appeal Procedures are in the Self-Insurance Agreement available at the Company office.

If there are any questions about a claim payment, the Administrator should be contacted. If it is desired to initiate an Appeal Procedure because there is a disagreement with the reasons why the claim was denied, the Administrator should be notified in writing. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

The responsibility for full or final determinations of eligibility for benefits; interpretation of terms; determinations of claim; and appeals of claim denied in whole or in part under the Plan rests exclusively with the Administrator.

CUSTOMER SERVICE DIRECTORY

Administrator:

Richard (Dick) Rodruck - 1.800.562.5226

Claims Consultant:

Diane Christensen - 1.800.562.5226

Coverage Questions:

Diane Christensen - 1.800.562.5226

Jenifer DeMarre - 1.800.562.5226

Eligibility:

Sue Rhoads - 1.800.562.5226

Jenifer DeMarre - 1.800.562.5226

Diane Christensen - 1.800.562.5226

Correspondence and Claim Filing Address:

Pacific Underwriters
P.O. Box 68787
Seattle, WA 98168

Telephone for all questions regarding coverage and claims:

1.800.562.5226

Administrator