

WAHKIAKUM COUNTY PUD
Health And Welfare Benefit Booklet

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GROUP COVERAGE AT A GLANCE

This “coverage at a glance” is a general overview. Wahkiakum County PUD, through the Public Utility Risk Management Services (PURMS) Self-Insurance Fund, provides the Plan described in this booklet. The Plan is administered by Pacific Underwriters. The coverages, benefits and amounts described may be changed at a later date. Any change in your and your dependent’s benefits, class or status will take effect only when all of the Plan terms have been met.

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

PLAN EFFECTIVE DATE

The Plan Effective Date is January 1, 2001.

SOME TERMS YOU SHOULD KNOW

You and your means you, the employee.

We, us, our and ours mean Wahkiakum County PUD.

Administrator means Pacific Underwriters.

Fund means the PURMS Self-Insurance Fund.

Insured or Covered Person means you or a dependent of yours while covered under this Plan.

Family Unit means you and your covered dependents.

A year is a calendar year running from January 1 through December 31.

Medicare means the benefits of the XVIII of the Social Security Act of 1965, and all amendments to it.

WHEN AM I ELIGIBLE FOR COVERAGE?

Employees

All active, full-time, employees including elected Commissioners are eligible for coverage. Eligibility of other employees will be determined upon commission approval.

Eligible dependents include:

- Your husband or wife.
- A natural child, adopted child or child legally placed for adoption including a child for whom you has assumed a total or partial legal obligation for support in anticipation of adoption, stepchild, or legally designated minor ward, under age 26, who is primarily dependent on you, spouse or non-covered legal parent for support. In addition, a child of yours will be eligible for coverage under this plan when required by a court order.

- Children who are incapacitated due to developmental disability or physical handicap and chiefly dependent upon you, your spouse, or non-covered legal parent for support and maintenance are also eligible for benefits, provided the dependent was covered immediately prior to the 26th birthday and the incapacity occurred prior to the 26th birthday. Benefits will be provided for the duration of the incapacity unless coverage terminates. Proof of the incapacity will be required.

APPLICATION FOR COVERAGE

To become covered under this plan, you must complete an enrollment form 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 Fund and you have completed any probationary period required by us. For dependents who are eligible and are included on your application, coverage begins on your effective date.

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

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

Please submit a new enrollment form to us if there is any change in your family's eligibility. Forms are available through us.

NEWBORN AND ADOPTED CHILDREN

For your natural newborn child, coverage will be retroactive to the date of birth provided we receive your application for the new dependent's coverage within 60 days following birth. For your adopted child, coverage will be retroactive to the date of placement for adoption or the date you assumed total or partial legal obligation for the child's support in anticipation of adoption if the Fund receives your application for the new dependent's coverage within 60 days following placement or your assumption of legal obligation for the child's support. For your natural newborn or 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 will apply to such child if enrolled for coverage under this plan within 60 days of birth, adoption, or placement for adoption.

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 Insureds and spouses covered under this plan as provided by law (including the “Erin Act”), if you apply for coverage as specified above.

DENTAL COVERAGE

SUMMARY OF BENEFITS

Reimbursement Levels for Allowable Benefits

Class I	70% through 100%
Class II	70% through 100%
Class III	Constant 50%
Annual Program Maximum	\$2,000.00

The payment levels for covered dental expenses arising, as a direct result of an accidental bodily injury is 100%, of the unused program maximum.

All covered employees and covered dependents are eligible for Class I, Class II, Class III and Dental Accident Benefits.

How to Use Your Program

The best way to take full advantage of your dental plan is to understand its features. You can do this most easily by reading this benefits booklet before you go the dentist. The booklet is designed to give you a clear understanding of how your dental insurance works and how to make it work for you. It also answers some common questions and defines a few technical terms.

Choosing A Dentist

You may select any licensed dentist.

Claim Form

American Dental Association-approved claim forms may be obtained from your dentist.

Predetermination of Benefits

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, called a "predetermination of benefits." This will allow you to know in advance what procedures are covered, the amount the Fund will pay toward the treatment and your financial responsibility.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this program, the benefit period is the 12-month period beginning January 1 and ending December 31.

Reimbursement Levels

Your program is an incentive plan. It is designed to encourage prevention by increasing from one benefit period to the next the amount paid by the Fund for preventive care and regular visits. An incentive period consists of 12 consecutive calendar months. The first incentive period starts on the first day of the month that an eligible person uses dental services. Subsequent incentive periods are based on that date.

Your incentive dental plan offers three classes of covered treatment. Each class also specifies limitations and exclusions (see the explanation of these terms elsewhere in this section).

Reimbursement Levels For Class I and Class II Procedures

During the first incentive period, the payment level for covered and allowable Class I (diagnostic and preventive) and Class II (basic) procedures is 70 percent. This payment level increases 10 percentage points each successive incentive period in which an eligible person obtains dental treatment covered by this program. The payment level increases to a maximum of 100 percent.

You must visit the dentist at least once during each annual incentive period in order to increase or maintain your payment level. If an eligible person fails to utilize benefits during an incentive period, the payment level will be decreased by 10 percentage points for each incentive period during which benefits are not used. This deduction will be made from the last payment level used by the Fund in making payment of the eligible person. In no event will the payment level be less than the initial 70 percent level.

Each eligible person establishes his or her own payment levels through utilization during incentive periods.

Reimbursement Levels For Class III Procedures

The payment level for covered and allowable Class III (major) procedures is 50 percent. The incentive provision described above does not apply to Class III procedures.

The payment level for covered dental expenses arising, as a direct result of an accidental bodily injury is 100 percent, up to the unused program maximum.

Limitations and Exclusions

Dental plans typically include limitation and exclusion, meaning that the plans don't cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this booklet under the sections called "Benefits Covered by Your Program" and "General Exclusions." They warrant careful reading.

Copayments (Coinsurance)

A copayment policy is typical of most insurance plans. This means the Fund will pay a predetermined percentage of the cost of your treatment, and you are responsible for paying the balance. What you pay is called the copayment. It is paid even after a deductible is reached.

Program Maximum

The program maximum is the maximum dollar amount a dental plan will pay toward the costs of dental care within a specific benefit period. You are personally responsible for paying costs above the annual maximum.

For your program, the maximum amount payable by the Fund for Class I, II and III covered dental benefits (including dental accident benefits) per eligible person is \$2,000 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

BENEFITS COVERED BY YOUR DENTAL PROGRAM

The following are Class I, Class II and Class III covered dental benefits under this program that are subject to the limitations and exclusions contained in this booklet. Such benefits (as defined) are available only when rendered by a licensed dentist or other Fund-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and the Fund.

The amounts payable by the Fund for Class I, II and III covered dental benefits are described under Reimbursement Levels in this booklet.

CLASS I

DIAGNOSTIC

Covered Dental Benefits

- Routine Examinations;
- X-rays;
- Emergency examination;
- Examination by a specialist in an American Dental Association recognized specialty;
- Fund-approved caries susceptibility tests.

Limitations

- Examination is covered twice in a benefit period;
- Complete series (4 bitewing x-rays and up to 10 periapical x-rays) or panorex x-rays are covered once in a 3-year period
- Supplementary bitewing x-rays are covered twice in a benefit period;

Exclusions

- Diagnostic services and x-rays related to temporomandibular joints (jaw joints);
- Consultations or elective second opinions;
- Study models.

PREVENTIVE

Covered Dental Benefits

- Prophylaxis (cleaning);
- Fissure sealants;
- Topical application of fluoride;
- Space maintainers when used to maintain space for eruption of permanent teeth.

Limitations

- Prophylaxis is covered twice in a benefit period (refer to Class II, Periodontics, Limitations for additional limitation information);
- Topical application of fluoride is covered twice in a benefit period when performed in conjunction with a prophylaxis, through age 18;
- Preventive therapies (e.g., fluoridated varnishes) approved by the Fund are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy. Children through age 18 are eligible for either topical application of fluoride or preventive therapies, but not both, as described above. Please note; these benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered;
- Fissure sealants are available for children through age 14. If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending dentist. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit only once in a 3-year period per tooth.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits);
- Cleaning or a prosthetic appliance;

- Replacement of a space maintainer previously paid for by the Fund.

CLASS II

RESTORATIVE

Covered Dental Benefits

- Amalgam, composite or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp);
- Stainless steel crowns.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period;
- If a composite or filled resin restoration is placed on a posterior tooth, an amalgam allowance will be made for such procedure. The difference in cost is your responsibility;
- Stainless steel crowns are covered once in a 2-year period;
- Refer to Class III Limitation if teeth are restored with crowns, inlays or onlays.

Exclusions

- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion;
- Overhang removal, re-contouring, or polishing of restoration.

ORAL SURGERY

Covered Dental Benefits

- Removal of teeth and surgical extractions;
- Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures;
- Treatment of pathological conditions and traumatic facial injuries.

Limitations

- General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other Fund approved licensed professional who meets the educational, credentialing and privileging guidelines established by the

proper local authority in conjunction with certain covered oral surgery procedures, as determined by the Fund.

Exclusions

- Iliac crest or rib grafts to alveolar ridges;
- Ridge extension for insertion of dentures (vestibuloplasty);
- Tooth transplants;
- General anesthesia/intravenous sedation for routine post-operative procedures.

PERIODONTICS

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include examinations, periodontal maintenance, periodontal scaling/root planing, periodontal surgery, and general anesthesia/intravenous sedation;
- Fund-approved site-specific therapies;
- Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration and occlusal guards (nightguards).

Limitations

- Examinations are covered twice in a benefit period;
- Under certain conditions of oral health, periodontal maintenance and/or prophylaxis may be covered up to a total of 4 times in a benefit period. Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered;
- Periodontal scaling/root planing is covered once in a 3-year period;
- Site-specific therapies approved by the Fund are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy. Plan note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered;
- Periodontal surgery (per site) is covered once in a 3-year period;
- Soft tissue grafts (per site) are covered once in a 3-year period;

- Periodontal surgery and site specific therapy must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment;
- General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other Fund-approved licensed professional who meets the education, credentialing and privileging guidelines established by the proper local authority in conjunction with certain covered periodontal surgery procedures, as determined by the Fund.

Exclusions

- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances;
- Gingival curettage;
- Site specific therapy is not covered when used for the purpose of maintaining non-covered dental procedures or implants;
- General anesthesia/intravenous sedation for routine post-operative procedures.

ENDODONTICS

Covered Dental Benefits

- Procedures of pulpal and root canal treatment;
- Services covered include pulp exposure treatment, pulpotomy and apicoectomy;

Limitations

- Root canal treatment on the same tooth is covered only once in a 2-year period;
- General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other Fund-approved licensed professional who meets the educational, credentialing and privileging of guidelines established by the Proper local authority in conjunction with certain covered endodontic surgery procedures, as determined by the Fund;
- Refer to Class III Limitation if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions

- Bleaching of teeth;

- General anesthesia/intravenous sedation for routine post-operative procedures.

CLASS III

PERIODONTICS

Covered Dental Benefits

- Under certain conditions of oral health, services covered are occlusal guards (nightguards) and complete occlusal equilibration. Please note; these benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.

Limitations

- Occlusal guards, including repairs, are covered once in a 3-year period;
- Complete occlusal equilibration is covered once in a lifetime.

Exclusions

- Periodontal splinting, crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances.

RESTORATIVE

Covered Dental Benefits

- Crowns, inlays (only when used as an abutment for a fixed bridge), onlays (whether they are gold, porcelain, Fund-approved gold substitute castings (except processed resin or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or filled resins.

Limitations

- Crowns or onlays on the same teeth are covered once in a 5-year period;
- Inlays are a covered benefit on the same teeth once in a 5-year period only when used as an abutment for a fixed bridge;
- If a tooth can be restored with a filling material such as amalgam or filled resin, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided;
- The Fund will allow the appropriate amount for an amalgam or composite restoration toward the cost of processed filled resin or processed composite restoration.

Exclusions

- A crown used as an abutment to a partial denture for purposes of recontouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth, whether or not a partial denture is required;
- Crowns used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or existing restorations with defective margins when no pathology exists;
- Crown and/or onlays placed because of weakened cusps or existing large restorations without overt pathology.

PROSTHODONTICS

Covered Dental Benefits

- Dentures, fixed bridges, removable partial dentures and the adjustment or repair of an existing prosthetic device;
- Surgical placement or removal of implants or attachments to implants.

Limitations

- Replacement of an existing prosthetic device is covered only once every 5 years and only then if it is unserviceable and cannot be made serviceable;
- Replacement of implants and superstructures is covered only after 5 years elapsed from any prior provision of the implant;
- Full, immediate and overdentures – the Fund will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restoration or specialized treatment;
- Temporary/interim dentures – the Fund will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after 12 months;
- Root canal treatment performed in conjunction with overdentures is limited to 2 teeth per arch and is paid at the Class III payment level;
- Partial dentures – If a more elaborate or precision device is used to restore the cast, the Fund will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided;
- Denture adjustments and relines – Denture adjustments and relines done more than 6 months after the initial placement are covered, except as noted under Temporary/interim dentures. Subsequent relines or jump rebases (but not both) will be covered once in a 12-month period.

Exclusions

- Duplication dentures;
- Personalized dentures;
- Cleaning of prosthetic appliances;
- Crowns and copings in conjunction with overdentures.

ACCIDENTAL INJURY

The Fund will pay 100% of covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused program maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

GENERAL EXCLUSIONS

- Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- Dentistry for cosmetic reasons.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth.
- Application of desensitizing agents.
- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, the Fund, in conjunction with the American Dental Association will consider if; 1) the services are in general use in the dental community; 2) the services are under continued scientific testing and research; 3) The services show a demonstrable benefit for a particular dental condition; and 4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
- General anesthesia/intravenous (deep) sedation, except as specified by the Fund for certain oral, periodontal or endodontic surgical procedures.
- Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections or prescription drugs.

- In the event an Eligible Person fails to obtain a required examination from a Fund - appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
- Broken appointments.
- Patient management problems.
- Completing insurance forms.
- Habit breaking appliances or orthodontic services or supplies.
- The Fund shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the Contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.
- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
- All other services not specifically included in this program as covered dental benefits.

Frequently Asked Questions about Your Dental Benefits

Can I choose my own dentist?

See "Choosing A Dentist" under the "How to Use Your Program" section in the front of this booklet.

What is the mailing address to send my claim forms?

The mailing address is Pacific Underwriters, PO Box 68787, Seattle, WA 98168.

Who do I call if I have questions about my dental plan benefits?

If you have questions about your dental benefits, call the Administrator at (800) 562-5226.

Why is the coverage less for tooth-colored fillings on my back teeth?

Tooth-colored fillings, or fillings made of composite resin, are considered to be cosmetic. Dental amalgams, or what we normally think of as silver fillings, are less expensive and clinically equivalent to composite resins. Because of this, your plan reimburses your dentist for the least costly clinically equivalent fillings in the back (posterior) teeth. If you have questions about this, feel free to discuss them with your dentist.

Do I have to get an “estimate” before having dental treatment done?

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, called a “predetermination of benefits”. This service is helpful because it will allow you to know in advance what procedures are covered, the amount the Fund will pay toward the treatment and your financial responsibility. However, this is not a requirement for coverage.

I am divorced. If my former spouse and I both have dental coverage, whose insurance covers the children first?

It usually depends on who has financial responsibility for the children. If the parents have joint custody, then the parent with the birthday earliest in the calendar year has primary coverage. If the custodial parent does not have financial responsibility, the parent who does has primary coverage.

My former spouse and I are divorced. What kind of documentation do I need to provide to the Fund to maintain the children’s dental coverage?

A parenting plan or statement of financial responsibility is required to verify which parent has primary coverage and which has secondary coverage for children in a divorce situation.

GLOSSARY

Alveolar - Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam - A mostly silver filling often used to restore decayed teeth.

Bitewing x-ray – An x-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gumline, as well as a portion of the roots and supporting structures of these teeth.

Bridge – A replacement for a missing tooth or teeth. The bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

Caries – Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Caries Susceptibility Test – A test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

Composite – A tooth colored filling, made of a combination of materials, used to restore teeth.

Crown – A restoration that replaces the entire surface of the visible portion of tooth.

Denture – A removable prosthesis that replaces missing teeth. A complete (or “full”) denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

Endodontics – The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Exclusions – Dental services not provided under a dental insurance plan.

Filled Resin – Tooth colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

Fluoride – A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish – A Fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

General Anesthesia – A drug or gas that produces unconsciousness and insensibility to pain.

Implant – A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay – A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intravenous (I.V.) Sedation – A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

Limitations – Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured.

Nightguard – A removable dental appliance – sometimes called an occlusal guard – that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). A nightguard is typically used at night.

Occlusal Adjustment – Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal Guard – See “Nightguard.”

Onlay – A restoration of the contact surface of the tooth that covers the entire surface.

Orthodontics – Diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture – A removable denture constructed over existing teeth or implanted studs.

Panorex X-ray – An x-ray, taken from outside the mouth, that shows the upper and lower teeth and the associated structures in a single picture.

Periodontics – The diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

Prophylaxis – Cleaning and polishing of teeth.

Prostodontics – The replacement of missing teeth by artificial means such as bridges and dentures.

Restorative – Replacing portions of lost or diseased tooth structure with a filling or crown to restore proper dental function.

Root Planing – a procedure done to smooth roughened root surfaces.

Sealants – A material applied to teeth to seal surface irregularities and prevent tooth decay.

Site-specific Periodontal Therapy – Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. The therapy is viewed as an alternative to gum surgery when conditions are favorable.

Temporomandibular Joints – The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

VISION/HEARING CARE BENEFIT

The Vision/Hearing Benefits of this program are based on allowable charges for covered services and supplies. If your ophthalmologist, optometrist, or optician, licensed physician (MD or DO) is a Network Provider, the allowable charge is the fee that he or she agrees to accept as full payment from us for covered services and supplies. You are only responsible for amounts over the Vision/Hearing Benefit's maximums and charges for services or supplies that are not covered.

Benefits are available for the listed vision/hearing services and supplies when such services and supplies meet all of these requirements.

They must be prescribed and furnished by a covered vision/hearing care provider.

They must not be excluded from coverage under this program.

They must be named in this benefit as covered.

Any deductible and coinsurance of other benefits in this program do not apply to this benefit.

COVERED SERVICES:

Hearing Examination:

100% for one Otologic (ear) examination by a physician and one audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation using the services of a Network Provider once each calendar year.

Coverage is \$40.00 for using the services of a non-Network Provider once each calendar year.

Eye Examinations:

100% using the services of a Network Provider once each 12 months.

Coverage is \$40.00 for using the services of a non-Network Provider once each 12 months.

Lenses and Frames:

100% after \$10.00 copay using the services of a Network Provider. A wide selection of frames and lenses are paid in full.

SCRATCH-COAT, ULTRA-VIOLET, ANTI-REFLECTIVE COATS ARE COVERED.
Note: Coatings will not be covered if lenses are purchased from a non-Network Provider.

Additional charges may be incurred for cosmetic extras (oversized, tinted).

Using a non-Network Provider, coverage is up to \$40/single vision lenses; bifocals \$60.00; trifocals \$80.00; lenticular \$125.00; frames \$45.00 after \$15.00 copay.

Lenses are covered once each 12 months; frames, once each 24 months.

Contact Lenses:

100% after \$10.00 copay for necessary contact lenses using a Network Provider; must be approved by optometric consultant.

\$105.00 annual coverage for cosmetic contact lenses fitting and follow-up fees; contacts are in lieu of spectacles, lenses and frames; examination is paid in full.

Using the services of a non-Network Provider, coverage is:

NECESSARY – up to \$210 after \$15 annual copay;

COSMETIC – up to \$105.00.

No other routine benefits or benefits for glasses, contact lenses, hearing aids or cochlear implants will be provided under this plan unless specifically stated. Copays apply to all services except x-ray and laboratory.

MEDICAL BENEFITS

CARE WITHIN THE SERVICE AREA

Within the service area, you can choose either of two benefit levels: Network benefits or Non-network benefits. Each time you need medical care you are free to decide which provider you want to use. Your choice will determine the level of benefits you receive. The level you choose will affect how your benefits will be paid.

NETWORK BENEFITS

The Network consists of physicians, hospitals and other providers who participate in the First Choice Health Network or Providence Preferred Network.

NON-NETWORK BENEFITS

The Non-network benefits are available when you use a Non-network provider. Non-network benefits are described elsewhere in this brochure. No Non-network benefits and no benefits outside the Service Area will be provided for the services of an approved massage therapist, an approved acupuncturist, an approved nutritionist or an approved naturopath.

EMERGENCY CARE

If you have a medical emergency, go to the nearest appropriate facility. Benefits will be provided at the level specified in the Payment Schedule for Network benefits.

Please refer to the Definition of Terms section to see how a medical emergency is defined for this plan.

CARE OUTSIDE THE SERVICE AREA

Outside the service area, benefits will be provided for care received from an out-of-area provider (see the Definition of Terms section) based on the allowed amount at the level specified in the Payment Schedule for Network benefits.

No benefits will be provided when you leave your state of residence to obtain care for any condition. The only exception is if this care is medically necessary and approved in advance, in writing, by the Fund.

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

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

HOW DO I FILE A CLAIM?

In the Service Area: be sure to present your identification card when receiving treatment. Filing claims for services of Network Providers is not necessary. If you receive a bill from your provider or hospital, please verify with the provider or hospital that the Fund has been billed. At the time of service you should inform your provider about copays that are re-

quired on your plan. Arrangements for paying copays should be handled directly between you and your provider.

Outside the Service Area: Present your identification card. The provider can verify coverage and file your claim with the Fund directly. When your claim is processed, you will receive an explanation of claims processing that will specify any amount you owe the provider. You will only be responsible for any deductible and coinsurance payments.

How to Submit Other Claims

When a provider or hospital does not bill the Fund 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 Fund:

- Insured's name, address and Social Security 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 DO I HAVE TO PAY FOR?

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

COPAYS

Each covered person will be required to pay the dollar amounts specified below or as specified in the Benefits section.

\$10 copay for each outpatient professional service (except lab and x-ray services) performed in the office, home, hospital, outpatient department or other facility. Copays apply to all outpatient professional services as noted in the Benefits section.

\$75 copay for each visit to a hospital emergency room for illness, injury or surgery (waived if directly admitted to the hospital as an inpatient).

Copays cannot be used to satisfy your annual deductible and will not accumulate toward your stoploss limits.

THE DEDUCTIBLE

Required for Non-network Benefits.

The deductible is the cost of covered medical expenses outside the Network benefits that you must incur and are responsible to pay before your Non-network benefits are available. No deductible is required for Network benefits.

The deductible amount under this plan is \$200 per person, per calendar year.

The allowed amount for any Non-network benefits provided by this plan can be applied to your deductible; however, any copays required by your plan will not apply to your deductible.

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

Deductible Carry-Over: Covered expenses incurred during the last three months of a calendar year and applied to the deductible may also be applied to the next 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 and the next calendar year as a result of the accident.

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 appropriate stoploss limit for the calendar year in which the hospitalization began.

How to Submit Proof of Your Deductible: As you incur deductible expenses, your provider should bill the Fund direct. If direct billing is not possible, submit your claim as specified in the "How Do I File A Claim?" section of this brochure as you incur expenses. You will receive itemized statements showing what amounts have been credited toward your deductible.

PAYMENT SCHEDULE

The schedule below shows many of the main benefits included in your plan. Additional benefits may in some cases be available and will be described in the Benefits section of this brochure. After you have satisfied your copay and any deductible requirements, benefits will be provided at the payment levels specified below or in the Benefits section of this brochure. Please read the entire brochure for details on these and other benefits, specific benefit limitations and maximums, waiting periods and exclusions.

Service	Network Benefits	Non-network Benefits
Ambulance Services	80%	80%
Ambulatory Surgical Center	100%	70%

Chemical Dependency Treatment Facility Services	100%	70%
Home Health and Hospice Care	100%	70%
Home Medical Equipment Company	100%	70%
Home Phototherapy	100%	70%
Hospital Services and Supplies	100%	70%
Infusion Therapy	100%	70%
Neurodevelopment Therapy	100%	70%
Phenylketonuria Formulas	100%	70%
Preventive Care	100%	0%
Professional Services as described in the Benefits section (unless otherwise specified)	100%	70%
Prostheses and Orthotics	100%	70%
Rehabilitative Services	100%	70%
Routine Eye and Hearing Exams	100%	\$40 maximum
Screening Mammograms	100%	70%
Skilled Nursing Facility Services	100%	70%
Smoking Cessation	80%	80%
Transplants	100%	See Benefits

Benefits Outside the Service Area

If you receive care outside the service area, you will receive the same benefits as in the Network. If you live inside the service area and become admitted as an inpatient while traveling outside the service area, you will receive the Network inpatient benefits.

STOPLOSS LIMITS

Your plan has two separate limits called “stoploss limits” – one applies to Network benefits and the other to Non-network benefits. The stoploss amounts are as shown below.

Network stoploss Limit:	\$2,500 per person \$7,500 per family, per calendar year
Non-network Stoploss Limit:	\$10,000 per person \$30,000 per family, per calendar year

When your eligible out-of-pocket coinsurance expenses for either the Network or the Non-network Benefits reach the appropriate stoploss limit, the payment level for most benefits within that Benefit only will increase to 100% of the allowed amount for the remainder of the calendar year. The coinsurance for Network benefits applies only to the Network stoploss and the coinsurance for Non-network benefits applies only to the Non-network stoploss. (Some benefits do not change to higher payment levels and the coinsurance for those benefits does not apply to the stoploss limits. Those exceptions are noted throughout the brochure.)

MAXIMUM BENEFITS

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 plan. In addition, up to \$20,000 of benefits paid will be reinstated automatically, against the lifetime maximum only, on January 1 of each year.

BENEFITS

All Non-network benefits are provided as specified after satisfaction of any deductible.

All covered benefits are subject to the limitations, exclusions and provisions of this plan.

Preventive Care

The services of a Provider will be provided for preventive care performed on an outpatient basis at the same level as benefits for illness conditions. The services of a physician, optometrist, or audiologist will be provided for routine eye and hearing examinations. A female may also refer herself directly to the following providers for covered services: physician, advanced registered nurse practitioner specializing in women’s health and midwifery, or physician’s assistant. The following services will be provided:

- Routine well baby care from birth.
- Routine pediatric, routine gynecological and adult physical examinations.
- Pediatric and adult immunizations.
- Office calls and related laboratory and x-ray services for cancer screening. (However, for mammography services, see the regular benefits of your plan.)

- One routine eye examination per calendar year to determine the need for a new or changed prescription.
- One routine hearing examination per calendar year.

Professional Services

The services of a Network Provider that 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 in the office, home, hospital or skilled nursing facility. The services of a Network Provider who is a physician, a physician's assistant, or an advanced registered nurse practitioner specializing in women's health and midwifery will be provided to a female when she refers herself directly for covered women's health care services. Covered women's health care services include gynecological care and general examinations as medically appropriate and medically appropriate follow-up visits. To receive the Network level of benefits for covered women's health care services, a female may refer herself directly to a provider who is a physician, a physician's assistant, or an advanced registered nurse practitioner specializing in women's health and midwifery. Copays apply to all services except x-ray, laboratory and inpatient care.

Hospital Services

The inpatient and outpatient services of an approved hospital will be provided for injury and illness (including services of staff providers billed by the hospital). Room and board limited to the hospital's average semiprivate room rate. You will be responsible to pay the emergency room copay for each hospital emergency room visit. All other services of the hospital outpatient department, except outpatient surgery, radiation and chemotherapy, are subject to the outpatient professional copay.

Hearing Aids:

Using the services of a Network Provider your program will pay a constant 75% of the allowable charge for a hearing aid device for the employee only. The maximum is \$4,000 in a period of four consecutive calendar years.

Coverage for the employee is 50% for using the services of a non-Network Provider, with the maximum benefit of \$3,000 in a period of four consecutive calendar years.

Batteries or other ancillary equipment, other than that obtained upon the initial purchase are not covered.

Ambulance Services

The services of an approved ground ambulance company will be provided to a maximum of \$2,000 per calendar year 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 Fund.

Ambulatory Surgical Center

The services and supplies of an approved ambulatory surgical center will be provided for injury or illness.

Blood Bank

The services and supplies of a recognized blood bank will be provided at 80% of the allowed amount.

Diabetes Care Training

The outpatient benefits of this plan will be provided for diabetic self-management training and education, including nutritional therapy, if recommended by a Provider with expertise in diabetes.

Home Health Benefit:

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 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 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 Fund for an extension of benefits. Limited extensions may be granted by the Fund if it determines that the treatment is medically necessary.

Any expenses for home care, which qualify both under this benefit and under any other benefit of this plan may be covered only under the benefit the Fund determines to be the most appropriate.

No benefits will be provided for the following:

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

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

Home Medical Equipment

Home medical equipment rented or purchased (if approved by the Fund) from an approved home medical equipment company will be provided for therapeutic use. Such equipment includes crutches, wheelchair, kidney dialysis equipment, standard hospital beds and medically necessary diabetic supplies such as blood glucose monitors, insulin infusion devices, insulin pumps and accessories to pumps. To be covered, equipment must meet certain criteria established by the Fund. Home medical equipment furnished by an approved hospital will be provided at the payment level specified for Non-network benefits in the Payment Schedule. Equipment ordered before your effective date of coverage will not be provided. Equipment ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of home medical equipment due to normal use or growth of a child will be provided.

“Home medical equipment” means the equipment can withstand repeated use; its only function is for treatment of a 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, three-wheeled scooters, 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 Fund may elect to provide benefits for a less costly alternative item.

Home Phototherapy

Services and supplies furnished by an approved home phototherapy provider will be provided for newborn hyperbilirubinemia (newborn jaundice).

Hospice Benefit

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 enteral 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 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 benefit 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 an approved hospital or 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 Fund determines to be the most appropriate.

If the benefit is exhausted, you may apply to the Fund for an extension of benefits. Limited extensions may be granted if the Fund 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

Services and supplies will be provided for infusion therapy furnished by an approved infusion therapy provider. Drugs and supplies used in conjunction with infusion therapy will be provided only under this infusion therapy benefit. No other benefits for infusion therapy will be provided under this plan.

Preadmission Testing for Surgery

The services of an approved physician and 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.

Prostheses and Orthotics

Benefits will be provided for the purchase of braces, splints, orthopedic appliances and other orthotic supplies, and for purchase of a prosthesis for functional reasons when replacing a missing body part, when obtained from 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 Fund 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

The inpatient services and supplies of an approved skilled nursing facility will be provided for injury or illness, limited to 90 days per calendar year. Room and board limited to the facility's average semiprivate room rate. Your physician must submit for approval by the Fund and periodically review a written treatment plan specifically describing the services to be provided. No custodial care is provided.

Special Equipment and Supplies

The following will be paid at 80% of the allowed amount: casts; colostomy bags and related supplies; catheters; surgical appliances; syringes and needles for allergy injection; dressings medically necessary for wounds, cancer, burns or ulcers and oxygen. Formulas for the treatment of phenylketonuria will be paid as shown on the Payment Schedule and will not be subject to the waiting periods described in the "When Won't Things be Covered?" 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

To receive the Network benefit level, you must contact your Provider. If you do not have your treatment coordinated by either your Provider but meet the other requirements of this benefit, you will receive the Non-network benefits.

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 supportive services and prescription drugs prescribed by the facility. Detoxification services are covered under the regular benefits of this plan. The services of an approved acupuncturist will be provided for Chemical Dependency treatment upon referral by the patient's Provider. Benefits will be provided to a maximum of \$5,000 every two calendar years and limited to a combined lifetime maximum of \$10,000 under this and any other Fund plan or any other group-sponsored plan. Any chemical dependency benefits provided during the previous 24-month period under this or any prior Fund plan or plan with another carrier will be charged against the two-year benefit limit. Chemical dependency means addiction to or abuse of alcohol, drugs, or any other chemical substance.

Whenever reasonably possible, pre-notification of treatment and a treatment plan 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 programs, long-term care of custodial care,

tobacco cessation programs and emergency service patrol. No other benefits for chemical dependency treatment are provided under this plan, except as described above for detoxification.

Mammography Benefit

The x-ray benefits of this plan will be provided for screening or diagnostic mammography services, if recommended by an approved physician, physician's assistant or advanced registered nurse practitioner.

Maternity Benefits

The benefits of this plan will be provided for treatment of pregnancy, and normal or cesarean delivery, and voluntary termination of pregnancy to the female Insured or male Insured's wife for services incurred while she is covered under this plan. 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. Benefits will be provided the same as for any other condition for treatment of complications arising from pregnancy. 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 any complications that may arise. A female may refer herself directly to an approved physician, physician's assistant, or advanced registered nurse practitioner specializing in women's health and midwifery for the maternity care benefits of this plan.

Neurodevelopmental Therapy Services

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 services. 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. A recognized occupational therapist for occupational therapy will be provided at 80% of the allowed amount.
- Regular inpatient hospital and skilled nursing facility benefits will be provided for an inpatient neurodevelopmental therapy admission when care cannot safely be provided on an outpatient basis. Hospital services must be provided in a hospital approved by the Fund for rehabilitative care.
- Your Network or Non-network physician must submit for advance approval by the Fund and must periodically review a written treatment plan specifically describing the neurodevelopmental therapy services to be provided.
- Benefits will be limited to \$1,000 per calendar year for all neurodevelopmental therapy services combined. The services of an approved massage therapist will be provided for physical therapy only upon referral by the patient's Provider. Copays apply to outpatient treatment. You will not be eligible for both the Rehabilitative Ser-

vices benefit and this benefit for the same services for the same condition. (Not subject to any stoploss provision.)

- No benefits will be provided for custodial care; maintenance (except as specified above), non-medical 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 subject to the application requirements (if any) for newborns described in the “When Am I Eligible?” 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?” 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.

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 \$30,000 per condition. You must be continuously covered under this or a prior medical plan with the Fund from the onset of the condition. Hospital services must be provided in a hospital approved by the Fund 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 Fund.

Physical or speech therapy in the office, home or hospital outpatient department will be paid to \$1,000 per calendar year. The services of an approved massage therapist will be provided for physical therapy only upon referral by the patient’s physician. The initial claim must be submitted with the physician’s prescription for the rehabilitative services. Copays apply to outpatient treatment. (Not subject to any stoploss provision.)

If you had an inpatient rehabilitative admission for the condition and did not exhaust your \$30,000 inpatient benefit, you may apply to the Fund for additional outpatient benefits beyond the \$1,000 limit. Limited extensions may be granted up to the balance of the unused inpatient benefit if the Fund determines the services to be medically necessary. No benefit 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; gym or swim therapy.

Sterilization Procedures

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

Temporomandibular Joint Disorders (TMJ)

Benefits will be provided for medical services furnished by an approved physician or hospital, or an approved physical therapist, for treatment of temporomandibular joint disorder. A TMJ disorder has one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Benefits will be limited to a maximum of \$1,000 per calendar year, not to exceed a lifetime maximum of \$5,000. Copays apply to outpatient services.

“Medical services” for the purpose of this TMJ benefit mean those services that are: 1) reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and 2) effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and 3) recognized as effective, according to the professional standards of good medical practice; and 4) non investigational or primarily for cosmetic purposes. All services must be provided or ordered by your physician and are subject to the waiting period described in the “When Won’t Things Be Covered?” section of this brochure, if any. Benefits for all surgical services related to TMJ must be authorized by the Fund in writing, in advance. The Fund will waive its advance notification requirement for treatment commencing within 48 hours, or as soon as is reasonably possible as determined by the Fund, after the occurrence of an accidental injury or trauma to the temporomandibular joint. No other benefits for TMJ will be provided by this plan.

Transplant Benefit

If you live inside the service area, the Network benefits of this plan will be provided to a combined lifetime maximum of \$200,000 for all medically necessary services or supplies relating to all transplants as follows, as determined by the Fund:

Benefits

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

- Heart
- Heart/lung (combined)
- Kidney
- Kidney/pancreas (combined)
- Lungs – single/bilateral

- Liver
- Cornea
- Bone marrow or other forms of stem cell rescue (only covered for certain conditions – see contract)

Benefits for all transplants must be authorized by the Fund in writing, in advance. All transplants must be performed in a facility approved by the Fund. 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's benefit limits.

Travel Expenses

Travel and lodging expenses for you and your family will be covered when you are required by the Fund to travel 30 miles or more outside the service area for medically necessary services related to an approved transplant. Benefits will be paid at the level specified for hospitals to a maximum of \$2,500 per transplant episode requiring travel and must be approved in advance by the Fund.

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 Fund.
- Donor and procurement costs incurred outside the United States unless approved by the Fund.
- 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.
- Any services or supplies relating to the transplant if you do not receive a referral from and have your care coordinated by your Provider (except as stated in this benefit if you live outside the service area).

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 and any prior medical plan with the Fund, whether or not the condition is preexisting or an emergency.

If you live outside the service area, you will be eligible for the benefits described above, except benefits will be payable at 80% of the allowed amount under the Non-network benefits of this plan. **You must follow all requirements of this benefit** including but not limited to obtaining advance approval from the Fund and using a facility approved by the Fund.

Mental Disorder Treatment

	Non-network Benefits	Network Benefits
Inpatient care, partial hospitalization, and residential treatment	12 days	12 days
Outpatient care, Subject to copay	15 visits	15 visits

Inpatient mental disorder care must be provided by an approved mental health provider including but not limited to psychiatric and state mental hospitals and approved community mental health agencies or an approved hospital or approved community mental health agency that has an inpatient facility. Outpatient mental disorder treatment must be provided by an approved mental health provider including but not limited to approved physicians, approved psychologists, approved registered nurses, approved MSWs, approved mental health counselors, approved marriage and family therapists (however, marriage and family counseling will not be covered) and approved community mental health agencies or a Non-network physician, psychologist, registered nurse, MSW, mental health counselor, marriage, and family therapist (however, marriage, and family counseling will not be covered) or community mental health agency.

If you use the services of any combination of Network and Non-Network Providers, the overall benefit maximums are limited to the amounts specified for Network benefits. No other benefits for treatment of mental disorders will be provided under this plan. (Outpatient benefits are not subject to any stoploss provision.)

Chiropractic Services

Will be provided for any health care service performed by an approved chiropractor if the service was within the lawful scope of the chiropractor’s license. Benefits will be paid at the level specified for professional services as described in the Payment Schedule. Network benefits will be provided only upon referral by the patient’s Network Provider.

OUTPATIENT PRESCRIPTION DRUG CARD PLAN

	Copay Amount
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Card Program	\$10.00 Brand-name drugs	\$ 5.00 Generic
Mail Order	\$10.00 (Brand-name/Generic)	

MANDATORY GENERIC

When there is a medically equivalent generic drug available, it is mandatory to use the generic drug. If the patient declines to accept the generic drug, he or she will be responsible to pay the difference between the brand name drug and the generic drug.

Covered Drugs: The following are covered unless listed as an exclusion below:

- Non-Injectable Federal Legend Drugs and some self-injectable Federal Legend Drugs (see exclusions)
- State Restricted Drugs
- Compounded Medications
- Insulin
- Insulin Needles and syringes
- Oral Contraceptives for the active employee or covered spouse (covered under the Mail Program only)
- Chemstrips, lancets and swabs for diabetic use (available by mail-order only)

Exclusions

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs."

- Injectable medications except insulin, and self-administered injectable drugs with no oral equivalent. Antigen and allergy vaccine are covered under the Physician Services benefit.
- Contraceptive medications or devices, except oral contraceptives for the active employee or covered spouse provided through the mail program.
- Drugs for which the primary purpose is to stimulate hair growth.
- Amphetamines and Anorexiant
- Growth Hormones
- Fertility drugs
- Retin-A, except when prescribed for employees or dependents age 26 or under

- Therapeutic devices or appliances
- Non-Federal Legend drugs
- Drugs labeled “Caution-limited by Federal Law to investigational use”, or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under Workers’ Compensation or Occupational Disease Law; any State or Governmental agency; or medication furnished by any other drug or medical service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or part, while he or she is a patient in a licensed hospital, rest home, sanitarium, Extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals. (See the Inpatient Prescription Drug benefit)
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order.
- FDA-approved drugs used for off-label indications, except as recognized as effective for treatment 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. (For definitions of “off-label”, “standard reference compendia”, and peer-reviewed medical literature”, please see the contract.) No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.

Dispensing Limits

Card Program

The amount of a drug, including insulin, which is to be dispensed per prescription or refill will be in quantities prescribed up to a 30 day supply or up to and including 120 units, whichever is lesser.

Mail Program

The amount of a drug, including insulin, which is to be dispensed per prescription or refill, will be in quantities prescribed up to a 90-day supply.

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 and any prior medical plan with the Fund, whether or not the condition is preexisting or an emergency. Benefits related to a transplant which was performed prior to your effective

date of coverage under this or any immediately preceding plan with the Fund will be subject to the preexisting condition waiting period described below.

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. However, if we require 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 non-coordinated 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 Fund later determines that the condition was preexisting.

LIMITATIONS AND EXCLUSIONS

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 Definition of Terms section) for treatment of an illness or injury, unless otherwise listed as covered.
- Acupuncture, except as specifically provided in the Chemical Dependency Treatment Facility benefit in the Benefits section, and except for pain management under a twelve visit limit per year, as administered by the Fund.
- 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, except for facilities that are included on the Fund's list of Network Providers, and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Government facilities outside the service area will not be covered (except as required by law for emergency services).
- 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 allowed amount as defined in the Definition of Terms 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.
- 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 non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast; and 4) for congenital anomalies when the patient has been covered under this plan from birth.
- Custodial care.
- 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
- Hearing aids and cochlear implants.
- Hospitalization 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.
- Marital and family counseling.
- 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).
- Preventive care, except as specifically provided in the Preventive Care Benefit in the Benefits section.
- Rehabilitative care, except as specifically provided in the Rehabilitative Services Benefit in the Benefits section.
- Routine eye and hearing exams, except as specifically provided in the Preventive Care Benefit in the Benefits section.
- Services provided by the us or any of our 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. This exclusion shall not apply to medications prescribed while under the care of a Physician.

- 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.
- Visual analysis, therapy or training; orthoptics.
- 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.
- Chiropractic services, except as specifically provided in the Chiropractic Services 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 uses for off-label indications will be provided only if recognized as effective for treatment 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. (For definitions of “off-label,” “standard reference compendia” and “peer-reviewed medical literature,” please see the contract.) NO benefits will be provided for any drug when the FDA has determined its use to be contraindicated.
- Family planning or contraceptive drugs or devices.
- Oral contraceptives for dependent children.
- Routine eye examinations; eyeglasses; contact lenses (except following cataract surgery).
- Dentistry and dental x-rays.

WHAT ELSE DO I NEED TO KNOW?

First and Third Party 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 provision of the contract, if you are fully compensated as defined in the contract.

COORDINATION OF BENEFITS

(Coverage under another group or individual plan)

Many people subscribe to more than one group or individual health care plan in order to protect themselves against the high costs of medical care. To keep the cost of your health care benefits as low as possible, the Fund will coordinate benefit payment 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 or individual plan, it is your responsibility to make sure that identical, itemized bills are submitted to both carriers at the same time. The Fund 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 an Insured will pay first.
2. The plan covering you as the dependent of a Insured whose day and month of birth occur earlier in the calendar year will pay before the plan covering you as the dependent of a Insured 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 order of benefit determination, the other plan's provisions 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 establishes financial responsibility for the health care of the child, the benefits of the plan that covers the child as the dependent of the parent with such financial responsibility will be determined first.
3. If none of the above rules established 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 Insured and his or her dependents, the 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 Insureds will not apply.
4. 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.

COVERAGE UNDER A PRIOR PLAN

If you were covered under another plan through the Fund, before coverage under this plan began, the following will apply:

- Any benefits (except mental disorder benefits) used under a prior plan during that calendar year will be charged against this plan's maximums for that same calendar year. Benefits for mental disorders used under a prior plan during that calendar year will be charged against this plan's maximum for Non-network benefits for mental disorders, if any. Any benefits used under a prior plan and not reinstated will also be charged to the benefit maximums of this plan.
- You will be allowed to credit your stoploss accumulation against your new stoploss limit for Non-network benefits during the same calendar year.
- You will be allowed to credit your eligible deductible expenses accumulated during a calendar year or during the last three months of the prior calendar year to your new deductible.
- You will receive credit toward satisfaction of the transplant benefit-waiting period under this plan only upon direct transfer from another Fund medical plan. For more information about waiting period credits, please see the Waiting Periods section.

SUBROGATION

Based on the following legal criteria, subrogation means that if you receive this program's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss any money recovered in excess of full compensation must be used to reimburse the Fund. The Fund will prorate any attorney's fees against the amount owed.

To the extent of any amounts paid by the Fund for an eligible person on account of services made necessary by an injury to or condition of his or her person, the Fund shall be subrogated to his or her rights against any third party liable for the injury or condition. The Fund shall, however, not be obligated to pay for such services unless and until the eligible person, or someone legally qualified and authorized to act for him or her, agrees to:

- Include those amounts in any insurance claim or in any liability claim made against the third party for the injury or conditions.
- Repay the Fund those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received.
- Cooperate fully with the Fund in asserting its rights under the Contract, to supply the Fund with any and all information and execute any and all instruments the Fund reasonably needs for that purpose.

Provided the injured party is in compliance with the above, the Fund will prorate any attorney's fees incurred in the recovery.

TERMINATION OF COVERAGE

When you are no longer eligible for coverage or leave the group, coverage will cease at the end of the same calendar month. However, you may be eligible for an extension of group

benefits as described below. The extension of coverage will end when our contract with the Fund terminates (except for the maternity extension).

COBRA

The provisions of this plan will be subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for groups that normally employed 20 or more employees during the previous calendar year and that are required by federal law to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Contact us for information on a COBRA continuation of coverage.

- Continuation coverage under this plan will be provided to a person entitled to such coverage under COBRA, when all requirements of COBRA, such as timely notices, have been complied with.
- We must notify the Fund of your election of COBRA continuation coverage within 60 days after the election, provided that all notice requirements of COBRA have been met in a timely manner. Your failure to make timely election will constitute a waiver of your rights to COBRA continuation coverage under this plan. Failure to provide timely notices may not, in all cases, terminate your right to continuation coverage; however, such failure will eliminate any obligation of the Fund to provide continuation coverage under this plan.
- If you are covered under another group health care plan when initially eligible for the COBRA continuation, 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 you elect a COBRA continuation of coverage, you will no longer be entitled to any other extension of coverage that may be available under your plan as explained in this brochure.

You or your dependents may be responsible for payment of the group rates during an extension of coverage. Payment must continue to be submitted through the Company.

See “When You Are No Longer Eligible For Coverage” for information on Conversion plans when your COBRA continuation ends.

Three-Month Leave of Absence:

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

Six-Month Extension:

If we are not eligible for COBRA or if you do not qualify for a COBRA continuation for any reason, you are eligible for a six-month extension, provided the rates are paid when due

through us as specified. This extension does not apply for employees whose employment was terminated for misconduct.

Maternity Extension:

If a female Insured or male Insured'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 "When Won't Things Be Covered?" section, if any, will apply.

Hospital Extension:

If you are an inpatient at a facility covered under this plan at the time this plan would be terminated for any reason, your effective date of termination will be postponed, and this plan will not be terminated for you until the first of the following events occur:

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

You will not be eligible for the hospital extension if you are eligible for a COBRA continuation.

Surviving Dependents: If an Insured is covered under this plan at the time of death, coverage for Dependents will remain in force for up to 60 days following your death.

If a Retiree is covered under this contract at the time of death, coverage for Dependents will be available under this contract on a self-pay basis after any continuation of coverage under COBRA.

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 Insureds may receive up to 12 weeks of leave during a 12-month period, as provided by FMLA, under the following circumstances:

- The birth of your child.
- The placement of a child with you for adoption or foster care.
- Care for your seriously ill spouse, parent or child.

- Your own serious physical or mental health condition.

Eligible Insureds 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 us for more detailed information on FMLA leaves.

PAYMENT OF RATES DURING A LABOR DISPUTE

If your compensation is discontinued due to a labor dispute, you may continue coverage during the dispute for as long as six months provided the rates are paid when due as specified in the contract. Your payments must continue to be submitted through the Company. If the Company 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 us for more information.

RELEASE OF MEDICAL INFORMATION

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

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

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

DEFINITION OF TERMS

We've worked hard to make your plan as easy as possible to understand and use. One way is by giving you clear definitions of terms you may encounter as you use your plan.

Allowed Amount

As determined by the Fund, means one of the following:

- Inside the service area, for a service or supply, the amount determined by the Fund under any applicable agreement between the Fund and the provider of a service or supply. If no agreement exists between the Fund or with one or more of the Fund's predecessor companies and the provider for services or supplies inside the service area, the allowed amount will mean the amount the Fund would have paid to a Network Provider for like services or supplies under this plan; you will be responsible for any additional charges.
- Outside the service area, for a service or supply, the amount as determined by the Fund. You will be responsible for any additional charges.

Coinsurance

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

Copay

A copay is a set fee you are required to pay each time certain services are performed before benefits are payable under this plan. Copays will not apply to your annual deductible and will not accumulate toward your stoploss limits.

Custodial Care

Care that, as determined by the Fund, 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 special diets, and supervision of medications that are ordinarily self-administered.

Hospital

An accredited general hospital 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 Fund. For the purpose of benefit determination, consideration will be given by the Fund 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 Fund.

- 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.

Physician

A licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.), or a licensed doctor of naturopathic medicine (N.D.) covered under this plan.

Network

First Choice Health Network and Providence Preferred Network.

Network Benefits

The level of benefits available when your care is given by a Network Provider. See the Benefits section for more information.

Network Providers

The Fund has made special arrangements through the Network to provide services to employees and their dependents. Network Providers agree to help control costs and to provide quality health care at a reduced cost to those covered by this plan. If you choose to obtain services from a non-network provider, the Fund will pay a percentage of the amount that would have been paid had the services been provided by a Network Provider.

It is the patient's responsibility to ascertain that the provider of service is a Network Provider. The list of Network Providers is subject to change, and an up-to-date list is available at the Administrator's office.

Non-network Benefits

The level of benefits available for providers other than Network Providers, unless specifically stated otherwise in the Benefits section. No Non-network benefits and no benefits outside the service area will be provided for the services of an approved massage therapist, an approved acupuncturist, an approved nutritionist or an approved naturopath.

Service Area

The geographic area where Providers are located as shown in the list of providers. The Network is continuing to expand the service area; please check with the Administrator's office for up to date information.

Stoploss

The dollar limits of coinsurance amounts that you are responsible to pay during a calendar year. After you have reached a stoploss limit, the Fund will pay most benefits within that stoploss category at 100% of the allowed amount for the remainder of the calendar year. Some benefits are not subject to the stoploss provision, as specified in the Benefits section; these benefits will always remain payable at the percentage level given in the Payment Schedule or in the applicable benefit section. In addition, **the following do not count toward any stoploss; your annual deductible; any copays; the difference between the allowed amount and the provider's actual charge; any coinsurance required when the preadmission approval provision is not satisfied; and any balances that remain after benefit limits have been expanded.**

APPEAL OF A CLAIM DENIAL – ALL CLAIMS

The complete Appeal Procedures are in the Self-Insurance Agreement available at the Fund 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

Bambi Harrison - 1.800.562.5226

Coverage Questions:

Diane Christensen - 1.800.562.5226

Bambi Harrison - 1.800.562.5226

Eligibility:

Ryan VanAckeren - 1.800.562.5226

Bambi Harrison - 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

A handwritten signature in black ink, appearing to read "Richard Rodruck", is written over a solid horizontal line.