HEALTH NET HEALTH PLAN OF OREGON, INC.

WASHINGTON PPO PLAN CONTRACT

Basic Benefit Schedule and
Group Medical & Hospital Service Agreement

2008

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Health Net Health Plan of Oregon
Washington PPO Plan
Policy Disclosures

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 DISCLOSURE

Health plans that provide medical and surgical benefits with respect to mastectomy shall provide, in a case of a Member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following services in a manner determined in consultation with the physician and the Member:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Benefits for reconstructive surgery may be subject to annual deductibles, if any, and Coinsurance consistent with those established for other benefits. Health plans and Employers may not deny a person eligibility to enroll in or to renew coverage solely for the purpose of avoiding coverage of breast reconstruction following a mastectomy.

SECOND MEDICAL OPINION

At the request of a Member, we will provide access to a second medical opinion from a Participating Provider of his or her choice, subject to maximum benefit limits and applicable deductible and Coinsurance or Copayment amounts.

SELF-REFERRAL FOR WOMEN'S HEALTH CARE SERVICES

Female Members may seek care for women's health services without Prior Authorization. You may seek these services from any Women's Health Care Provider. Facility services such as those provided by Hospitals or Outpatient Surgical Centers may require Prior Authorization.

THE RIGHT TO EXERCISE CONSCIENCE

Health care Providers or Employers have the right not to provide termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your Employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another Provider, with no added cost to you.

MENTAL HEALTH SERVICES AND YOUR RIGHTS

Please Note: All health plans are required by the Washington State Office of the Insurance Commissioner to provide this statement. Please read the information and call one of the numbers listed within this statement with any questions.

Health Net Health Plan of Oregon, Inc. and state law have established standards to assure the competence and professional conduct of mental health service Providers in order to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan, and to know the limitations on your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact us at (888) 802-7001.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at (800) 562-6900. If You have a concern about the qualifications or professional conduct of your mental health service Provider, please call the State Department of Health at (360) 236-4700.

The Office of Insurance Commissioner requires that the following questions and responses be provided to each Member prior to enrollment:

(a) "What are the steps that must be taken to have outpatient mental health services paid for by my plan?"

Prior Authorization*, predetermination of Medical Necessity, precerification of benefits and eligibility or Referral required.

*Prior Authorization is not required for involuntary commitment to a facility for mental health treatment. Notification of the emergency admission is required as soon as reasonably possible.

(b) "What information about my mental condition will anyone other than my mental health Provider see?"

Diagnostic details.
Treatment codes.
Treatment plans, including expected outcomes.
Progress notes (some Providers).

(c) "Do I have to pay a higher Copayment, Deductible, or other charges than I pay for my other covered medical services to get mental health services under this plan?"

Same	Less	More	
X			Deductibles
X			Copayments
X			Co-insurance

(d) "What is the maximum number of Medically Necessary Inpatient days and outpatient visits I can get each year under this plan?"

Inpatient Days	Outpatient Visits	
X		Up to eight days
	X	Up to twelve visits

(e) "What is the average number of outpatient visits this plan pays for people who have been provided mental health services?"

Less than ten.

(f) "In which of the following circumstances where I might need mental health services would I find them excluded or subject to restrictions or limitations other than Medical Necessity?"

A court orders treatment.
There are diagnosed learning disabilities.
There is a diagnosed mental disorder related to sexual functioning, or a sex change.
Couples or marriage therapy - in the absence of a mental health diagnosis.
Custodial care.
Behavioral modification classes or training.

(g) "What is this plan's most common goal in financing treatment in adults? In children?"

Stabilization and symptom management.
Return to previous functioning.
Ongoing maintenance for long-term illness.

Health Net Health Plan of Oregon
Washington PPO Plan
Basic Benefit Schedule

Article 1 - General Terms Under Which Benefits Are Provided

Throughout this Basic Benefit Schedule, the terms "we," "our" and "us" refer to Health Net Health Plan of Oregon, Inc. and the terms "you" and "your" refer to the Subscriber and to each Enrolled Dependent unless otherwise specified.

You are entitled to receive the benefits set forth in this Benefit Schedule subject to the following conditions:

1.1 All benefits are subject to the terms, conditions and definitions in the Group Medical and Hospital Service Agreement and the exclusions and limitations in Article 9 – Exclusions and Limitations of this Basic Benefit Schedule, including payment of any applicable Copayments and/or Coinsurance identified in the attached Copayment and Coinsurance Schedule.

1.2 All services other than the limited preventive care services outlined in the Agreement are covered only if Medically Necessary and required in accordance with accepted standards of medical practice as determined by the Medical Director.

1.3 The fact that a Provider may provide, prescribe, order, recommend, approve, refer or direct a service or supply does not, in and of itself, make the service or supply a covered benefit. To qualify as covered benefits, all services and supplies must be expressly set forth as benefits in this Benefit Schedule.

Even though a Hospital or other provider may be a Participating Provider, during your visit or stay you may receive services which are performed by Providers not in our PPO network. We recommend that you contact your attending Provider to discuss the ancillary Providers that may be used for your services, as these Out-of-Network Provider charges will be reimbursed at the Out-Of-Network level.

1.4 A service or supply not expressly included in this Benefit Schedule is not a covered benefit, even if it is not specifically listed as an exclusion in Article 9 – Exclusions and Limitations.

1.5 Specialty Care Providers. Medical Services for certain conditions or certain treatment procedures may be provided only at Participating Providers that we designate as Specialty Care Providers. Services which require use of a Specialty Care Provider include but are not limited to: 1) Home Health Care (Article 7.1); 2) home infusion services (Article 7.2); 3) organ and tissue transplant services (Article 7.8); and 4) Durable Medical Equipment (Article 7.9). We shall have the right to require a Member to use a designated Specialty Care Provider as a condition to receive coverage under this Agreement. Specialty Care Providers may be located anywhere in the United States. Members may be required to travel out of the Service Area to receive care. If a Member is required by us to use a Specialty Care Provider outside the Service Area, we will pay reasonable transportation, board and lodging expenses for the Member, to be determined by us based upon individual circumstances, including without limitation the distance between the Member's home and the Specialty Care Provider, and the Member's medical condition.

Article 2 - Physician Services

Medically Necessary Physician services are covered as follows:

2.1 Women's and Men's Health Care Services**.** Yearly breast and pelvic exam and Pap test are covered. Screening mammography is covered as follows:

Age 35-39	One baseline mammogram

Age 40 and over	Annually

Additional mammograms, pelvic exams, and Pap tests are covered as Medically Necessary.

Prostate cancer screening delivered upon the recommendation of a Member's Provider is covered.

The deductible, if any, is waived for services under this Article which are billed as preventive care.

2.2 Allergy Injections. Administration of treatment compounds, solutions and medications for allergy care is covered.

2.3 Diagnostic Services. Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imaging and diagnostic services are covered. Imaging services, including but not limited to MRIs and CT and nuclear scans, require Prior Authorization. Hearing tests in support of a diagnosis are covered.

Exclusions and Limitations: Screening audiometry and tympanograms not in support of a diagnosis are not covered.

2.4 Radiation Therapy and Chemotherapy. Radiation therapy and chemotherapy are covered. Prior Authorization is required.

Chemotherapy is the use of anti-cancer drugs to treat conditions including, but not limited to cancer. The chemotherapy benefit covers anti-cancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs, and medical supplies related to the mixing and administration of the drugs.

2.5 Office Visits. Your office visits, including diagnostic examination and treatment of illness or injury, are covered. Office procedures require Prior Authorization.

2.6 Physician Services While Hospitalized. The services of Physicians during a covered hospitalization, including services of primary care providers, specialist surgeons, assistant surgeons, anesthesiologists, pediatrician visits to an Enrolled newborn Child, and other appropriate medical personnel, are covered.

2.7 Home Visits. Visits to your home are covered.

2.8 Specialty Physician Services. Services of specialty Physicians and other specialty providers are covered.

2.9 Surgery. Inpatient or outpatient surgical procedures are covered only when Prior Authorized or as Emergency Medical Care.

Article 3 - Hospital Inpatient Services

Medically Necessary Hospital inpatient services are covered as follows:

3.1 Hospital Inpatient. Inpatient services are covered only when Prior Authorized or as Emergency Medical Care.

3.2 Hospital Room and Board. While you are a patient in a Hospital, an average two-bed accommodation; general nursing care; meals; special diets; use of operating room and related facilities; intensive care unit and services; X-ray, laboratory, and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; radiation therapy; chemotherapy other than high dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue procedure; inhalation therapy; internal Prosthetic Devices, such as pacemakers and hip joints, approved by the Food and Drug Administration and implanted during a surgery pursuant to a Prior Authorization. Single occupancy rooms are covered at those facilities which only offer single occupancy accommodations, but are not covered merely for patient convenience or preference.

3.3 Maternity Hospitalization. Refer to Article 5 – Maternity Benefits.

3.4 Newborn Nursery Care. Routine care in the Hospital nursery is covered for the newborn Child. See Article 4.3 of the Group Medical and Hospital Service Agreement for newborn child enrollment guidelines.

3.5 Exclusions and Limitations: A private room or services of private or special duty nurses other than as Medically Necessary or when the only accommodation offered when you are an inpatient in a Hospital. Personal comfort items, such as television, telephone, lotions, shampoos, guest meals, housekeeping services, etc. Prescriptions relating to an inpatient confinement filled at a hospital pharmacy prior to discharge for use at home (take-home medications).

Article 4 - Outpatient Services

Medically Necessary outpatient services are covered as follows:

4.1 Diagnostic Services. Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imaging and diagnostic services are covered. Imaging services, including but not limited to MRIs and CT and nuclear scans, require Prior Authorization. Outpatient services may be provided in a non-hospital based health care facility or at a Hospital.

4.2 Radiation Therapy and Chemotherapy. Radiation therapy and chemotherapy are covered. Prior Authorization is required.

Chemotherapy is the use of anti-cancer drugs to treat conditions including, but not limited to cancer. The chemotherapy benefit covers anti-cancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs, and medical supplies related to the mixing and administration of the drugs.

4.3 Outpatient Surgery. Outpatient surgery is covered only when Prior Authorized or as Emergency Medical Care.

Article 5 - Maternity Benefits

Medically Necessary maternity care is covered as follows:

5.1 Availability. Maternity benefits are available for all Members (Subscriber, Subscriber's Enrolled spouse, and a Subscriber's Enrolled Dependent Child).

5.2 Prenatal and Postnatal Care. Prenatal and postnatal care are covered. Coverage includes prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy.

5.3 Hospital Room and Board. Hospital room and board for the mother are covered the same as for any other covered illness or injury. We will not restrict benefits for any Hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, we may pay for a shorter stay if the attending Physician, after consultation with the mother, discharges earlier. We will not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. Length of stay of up to 48 hours (or 96 hours) does not require Prior Authorization. However, stays beyond 48 hours (or 96 hours) require Prior Authorization. Refer to Article 5 of the Group Medical and Hospital Service Agreement for further detail of the Prior Authorization process.

We must be notified of admission within 24 hours or on the first business day after admission. Once the hospital notifies us of the maternity admission, we will contact the hospital's Utilization Review department to discuss the case. The Utilization Review department may then perform a day-to-day review of the mother's care. If the admission goes beyond the 48-hour (or 96-hour) stay, documentation for medical necessity must be provided to us before benefits are paid as outlined in this Agreement.

5.4 Delivery and Nursing Care. Delivery services and nursing care are covered in a Hospital, birthing center or at home. Charges from Providers offering delivery care under the scope of a professional license are covered.

Article 6 - Emergency Medical Care

Emergency Medical Care is covered inside or outside the Service Area without Prior Authorization. See definitions in Article 2 of the Group Medical and Hospital Service Agreement. Benefits payable to Non-Participating Providers are paid at the Non-Participating Provider Level specified in the Coinsurance Schedule.

6.1 Emergency Inside the Service Area. If you have an Emergency Medical Condition inside the Service Area and you reasonably believe that the time required to contact your primary care Provider or to go to a Participating Provider Hospital or urgent care facility would seriously jeopardize your health (including an unborn child), medical care should be sought from the nearest Provider appropriate for the severity of your condition (physician's office or clinic, urgent care center, or Hospital emergency room) or call 911.

6.2 Emergency Outside the Service Area. If you have an Emergency Medical Condition outside the Service Area and reasonably believe that the time required to contact your primary care Provider would seriously jeopardize your health (including an unborn child), medical care should be sought from the nearest Provider appropriate for the severity of your condition (physician's office or clinic, urgent care center, or Hospital emergency room) or call 911.

6.3 Emergency Room. Services of a Hospital emergency room are limited to treatment of an Emergency Medical Condition and are not covered if merely for your convenience. Emergency Medical Condition means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

6.4 Notification. If you are hospitalized for an Emergency Medical Condition, notice of the admission sufficient to establish your identity and the institution to which you were admitted must be given to us on the first business day after admission or as soon as medically possible.

6.5 Follow-up and Continued Care. To ensure the maximum available benefits under this Agreement, you should obtain your follow-up care after Stabilization of an Emergency Medical Condition from Participating Providers and in accordance with any Prior Authorization requirements. If you are hospitalized in a Non-Participating Provider Hospital and require continuous care, we will arrange to have you transferred to a Participating Provider as soon as Stabilization has occurred.

6.6 Ambulance Transport. Licensed ground or air ambulance services are covered in the event of an Emergency Medical Condition. The maximum benefit is shown on the Copayment and Coinsurance Schedule.

Exclusions and Limitations: Ambulance transport that is not Emergency Medical Care is not covered unless Prior Authorized or arranged by us.

Article 7 - Other Services

Other Medically Necessary services will be covered as follows:

7.1 Home Health Care. Home Health Care for Skilled Nursing Services is covered in your home or place of residence which is not a Skilled Nursing Facility. The maximum benefit is shown on the Copayment and Coinsurance Schedule. Prior Authorization is required.

Exclusions and Limitations: We may utilize a Specialty Care Provider of home health services if you live the Service Area.

7.2 Home Infusion. Medically Necessary home infusion is covered when provided in lieu of hospitalization or skilled nursing facility care. Medically Necessary home injectables except insulin are covered when Prior Authorized.

Exclusions and Limitations: We may utilize a Specialty Care Provider of home infusion services if you live in the Service Area.

7.3 Skilled Nursing Care. Skilled Nursing Service in a participating Skilled Nursing Facility is covered. The maximum benefit is shown on the Copayment and Coinsurance Schedule. Prior Authorization is required.

7.4 Hospice Care. Hospice care is covered if you are terminally ill (a patient considered to be within the last six months of life). Prior Authorization is required.

7.5 Rehabilitation Therapy. The following are covered when expected to significantly improve an acute condition or acute exacerbation of a chronic condition: short-term Hospital-based or outpatient physical, occupational and speech therapy, cardiac rehabilitation, rehabilitation therapy following a covered mastectomy. The maximum benefits for inpatient and outpatient treatment are shown on the Copayment and Coinsurance Schedule. Prior Authorization is required. The Calendar Year maximum for outpatient rehabilitation therapy does not apply to services which are billed as Home Health visits.

Exclusions and Limitations: Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including but not limited to public speakers, singers, cheerleaders. Speech therapy for developmental delay, except in the case of swallowing deficit or as provided in Article 7.22 Neurodevelopmental Therapy. Speech therapy for emotional problems and/or disorders. Hearing therapy.

7.6 Diabetes Management. The following is covered in relation to the treatment of: insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes:

a. Outpatient diabetes self-management training and education, including medical nutrition therapy, as ordered by the health care provider is covered. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes.

b. Supplies and equipment related to Diabetes Management, as described in 7.10.a.

7.7 Health Education Services. Instruction in the appropriate use of health services and the contribution you can make to the maintenance of your own health is covered up to the limits set forth in this Article. Health education services shall include instruction in personal health care measures and information about services, including recommendations on generally accepted medical standards for use and frequency of such service. Qualifying classes include: prenatal/child birthing, exercise, healthy heart, first aid/CPR, weight management, stress management, and smoking cessation. Qualifying classes must be taken at a Hospital or clinic.

a. We will cover up to the maximum reimbursement amount shown on the Copayment and Coinsurance Schedule for each health education class.

b. The total benefit under this Article is not to exceed the Calendar Year maximum shown on the Copayment and Coinsurance Schedule.

7.8 Organ and Tissue Transplants.

Exclusion period. A 12-month Exclusion Period applies for services related to any organ or tissue transplant.

a. The following organ and tissue transplants are covered: kidney transplants; cornea transplants; heart transplants; liver transplants; lung transplants; heart-lung transplants; concurrent kidney-pancreas transplants for uremic insulin-dependent diabetics; artificial pump as a bridge to cardiac transplants; and autologous or allogeneic bone marrow transplants, stem cell rescue or hematopoietic support (all referred to herein as transplants) only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease or Wiskott-Aldrich Syndrome, neuroblastoma, Hodgkins and non-

Hodgkins lymphoma and for breast cancer when necessary to support high dose chemotherapy. No other organ or tissue transplants are covered.

b. We will direct you to a designated Specialty Care Provider in accordance with Article 1.5. Services provided by other than the designated Specialty Care Provider will not be covered. Coverage is conditioned upon your acceptance into the transplant program. Coverage may also be subject to approval by a Transplant Evaluation Committee designated by us. The Committee shall have complete discretion in determining whether or not a transplant will be covered and will consider factors such as the treatment's effectiveness in improving the length and quality of life; the mortality and morbidity associated with the treatment; alternative treatment methods; the current medical and scientific literature; the positions of governmental agencies regarding the treatment; community standards of care; and your physical and mental condition.

c. The lifetime maximum benefit is shown on the Copayment and Coinsurance Schedule and includes all amounts paid for transplant services. The lifetime maximum includes all covered services, supplies and pharmaceuticals required in connection with a covered transplant as follows: 1) evaluation of a transplant candidate; 2) tissue typing; 3) a covered transplant procedure and any complications resulting from such procedure; 4) scheduled follow-up care; 5) anti-rejection drugs; and 6) transportation and living expenses in connection with those services when we require you to receive care from a Specialty Care Provider outside the Service Area. When the recipient of a covered transplant is a Member, donor costs directly relating to surgical removal of the organ from the donor, as well as the costs of treating complications directly resulting from the surgery, will also be paid under the limits of this benefit.

d. Prior Authorization is required for transplant evaluation, services, and procedures related to a transplant.

e. Exclusions and Limitations: All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered. Services for an organ donor or prospective organ donor when the transplant recipient is not a Member. Organ and bone marrow search, selection, transportation and storage costs. Non-human or artificial organs and the related implantation services. Permanent or temporary implantation of artificial or mechanical devices to replace or assist human organ function until the time of organ transplant, except for dialysis to maintain a kidney and artificial pump bridge to cardiac transplants. High dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue. Transplants disapproved by our Transplant Evaluation Committee. Bone marrow transplantation, stem cell rescue or hematopoietic support for human gene therapy (enzyme deficiencies, severe hemoglobinopathies, primary lysosomal storage disorders). All services in excess of the lifetime maximum benefit for organ and tissue transplants. Transplant services not Prior Authorized and/or not provided at the Specialty Care Provider designated by us.

7.9 Durable Medical Equipment and External Prosthetic Devices. Durable Medical Equipment, including your initial rental or purchase, is covered provided it is the least costly alternative that achieves a medically acceptable result. External Prosthetic Devices are covered as Durable Medical Equipment. Medically Necessary lenses for the treatment of aphakia and keratoconus are covered as Durable Medical Equipment. The maximum benefit is shown on the Copayment and Coinsurance Schedule. Prior Authorization is required. Repair or replacement of Durable Medical Equipment is not covered.

The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.

Exclusions and Limitations: We may utilize a Specialty Care Provider of Durable Medical Equipment if you live in the Service Area.

7.10 Medical Supplies. Medical supplies are covered as follows.

a. Appropriate and Medically Necessary diabetic equipment and supplies dispensed in accordance with any formulary adopted by us are covered, including but not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits.

b. Ostomy supplies are covered, including flanges, pouches, irrigators, irrigator sleeves and drains, closed-end pouches, stoma caps, ostomy deodorant, belts, convex inserts, drain tube adapters, drainable pouch clamps, medical adhesive, replacement filters, security tape, and skin barriers.

Exclusions and Limitations: wound care products; incontinence products; generic multi-use products; reusables.

c. Non-durable supplies required for the function of Durable Medical Equipment are covered.

d. The first pair of Medically Necessary eyeglasses or contact lenses following covered cataract surgery is covered. Contact our Customer Contact Center for benefit limitations.

e. Allergy serums, treatment compounds, solutions, and medications are covered. Substances administered by therapeutic injection in a Provider's office are covered.

f. Non-durable medical supplies provided in the Provider's office are covered.

g. Excluded: All other non-durable medical supplies.

7.11 Blood. Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered.

Exclusions and Limitations: Extraction and storage of self-donated (autologous) or family member or friend blood and derivatives.

7.12 Mental Health Benefits. Benefits for treatment of Mental Disorders included in the Diagnostic and Statistical Manual of Disorders are provided up to the benefit limits shown on the Copayment and Coinsurance Schedule. Prior Authorization is required, except in the case of a Member who is involuntarily committed to and subsequently treated in a state hospital.

This Agreement will never provide less than the minimum benefits required by state and federal laws.

7.13 Chemical Dependency Treatment

Inpatient, outpatient, and professional services benefits are available for covered Chemical Dependency conditions. Prior Authorization is required for services other than detoxification. The combined benefit limit for inpatient and outpatient Chemical Dependency Treatment is shown on the Copayment and Coinsurance Schedule.

Coverage for Chemical Dependency treatment includes:

1. Medically Necessary services and supplies of a Provider, facility, or program approved under 70.96A.020 RCW for both Inpatient and outpatient care; and

2. Detoxification, supportive services, and approved prescription drugs prescribed by the Provider or facility, licensed according to 70.41 RCW. Medically Necessary detoxification services are covered as an Emergency Medical Condition so long as the patient is not yet enrolled in other Chemical Dependency treatment. Charges incurred for detoxification services do not apply toward any Chemical Dependency dollar maximums; these services will be paid as any other medical benefit.

Coverage under this provision is limited to the specific services listed above and does not include:

1. Alcoholics Anonymous or other similar Chemical Dependency programs or support groups;

2. Court ordered assessments or other assessments to determine the Medical Necessity of court order treatments;

3. Court ordered treatment and/or treatment related to the deferral of prosecution, deferral of sentencing or suspended sentencing, or treatment ordered as a condition of retaining motor vehicle driving rights, when no Medical Necessity exists;

4. Emergency patrol services;

5. Information and referral authorization services;

6. Information schools; or

7. Long term or residential custodial care.

7.14 Nonprescription Elemental Enteral Formula. Nonprescription elemental enteral formula for home use is covered if the formula is Medically Necessary for the treatment of severe intestinal malabsorption or for the treatment of phenylketonuria,. Prior Authorization is required, except for the treatment of phenylketonuria.

7.15 Inborn Errors of Metabolism. Clinical visits, biochemical analysis, treatment and medical foods are covered for inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes diagnosis, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Prior Authorization is required. "Medical foods" are defined as those formulated to be consumed or administered enterally under the supervision of a Physician, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

7.16 Case Management. We will have the right to authorize benefits for services and supplies excluded or not specifically covered under this Agreement as a substitute for other, possibly more costly, covered services or supplies. Such alternative benefits shall be determined by us, in advance, in cooperation with you and your Provider and will only be covered upon Prior Authorization. The decision on the course of treatment shall remain up to you and your Provider. Our decision in any specific instance to authorize benefits that would not otherwise be covered under this Agreement shall not commit us to cover the same or similar benefits for the same or any other Member in other instances. By authorizing alternative benefits, we shall not waive our right to enforce all terms, limitations and exclusions of this Agreement.

Included under this case management provision is the substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.

Such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

Substitution of less expensive or less intensive services shall be made only with the consent of the Member and upon the recommendation of the Member's attending physician or Provider that such services will adequately meet the Member's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual Member.

7.17 TMJ. Services for the diagnosis and treatment of Temporomandibular Joint Syndrome are covered. The lifetime maximum benefit is shown on the Copayment and/or Coinsurance Schedule. Copayments and Coinsurance payments for TMJ services do not apply to your out-of-pocket maximum.

7.18 Oral and Maxillofacial Services. The following oral and maxillofacial services are covered:

a. Oral and surgical care for tumors and cysts (benign or malignant); and

b. Treatment of cleft lip, cleft palate, or other maxillofacial congenital anomalies of a child.

7.19 Dental Anesthesia. General anesthesia services and related facility charges will be covered in relation to a dental procedure if such services and related facility charges are Medically Necessary because the Member:

a. Is under the age of seven, or physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office; or

b. Has a medical condition that the Member's Physician determines would place the Member at an undue risk if performed in a dental office. The procedure must be approved by the Member's Physician.

The services must be Prior-Authorized and must be performed in a hospital or in an Ambulatory Surgery Center. The dental procedures performed are only covered as specifically outlined in this Agreement.

7.20 Dental Injury. Dental services required because of an injury by external force or trauma are covered up to a maximum of $1,000 provided that the services are furnished within 12 months after an injury or accident which occurred while covered under this contract.

Exclusions and Limitations: Damage to teeth caused by chewing or biting is not considered a dental injury. Covered services include only that dental treatment required to restore function and appearance to a pre-injury level, and are limited to the least costly alternative which achieves a medically acceptable and effective result. If you are also covered under a Health Net Health Plan of Oregon, Inc. dental plan us, benefits for services covered under this provision will be paid before any available benefits for those same services are paid under your dental plan.

7.21 Reconstructive Surgery.

a. Reconstructive Breast Surgery. Reconstructive breast surgery following a covered mastectomy which resulted from disease, illness or injury is covered. If you receive benefits for a mastectomy and elect breast reconstruction with the mastectomy, benefits include coverage for: reconstruction of the breast on which the mastectomy has been performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; treatment of physical complications from all stages of mastectomy, including lymphedemas; and inpatient care related to the mastectomy and post-mastectomy services.

b. Other Reconstructive Surgery. We will cover Reconstructive Surgery that: (1) we determine to be Medically Necessary to repair a significant functional disorder as a result of illness or injury; or (2) is performed to repair congenital defects of a child.

Exclusions and Limitations: All other reconstructive breast surgery; reduction or augmentation mammoplasty except as provided in this Article.

7.22 Neurodevelopmental Therapy (under age 7). Charges for Medically Necessary neurodevelopmental therapy (including physical, speech and occupational therapy) are covered when provided to Dependents under age seven by occupational, physical, and speech therapists. This includes services to restore and improve function, and services for maintenance care in cases where significant deterioration in the Dependent's condition would result without the service. Prior Authorization is required. Benefit limits are for inpatient and outpatient services combined.

7.23 Alternative Care Benefit – Chiropractic Services, Acupuncture Services, Naturopathic Services, Massage Therapy.

Services and supplies are covered only when obtained from licensed Providers.

a. Benefits are provided for:

1. Office visits to Providers of chiropractic, acupuncture, naturopathic medicine, and Medically Necessary massage therapy. Copayments or Coinsurance are required for each covered visit, as shown on the Copayment and Coinsurance Schedule.

2. Diagnostic testing and radiology ordered or performed within a chiropractic or naturopathic scope of license.

b. Exclusions and Limitations:

1. Benefits for manipulations, acupuncture and massage therapy are limited to the visit maximums shown on the Copayment and Coinsurance Schedule.

2. Diagnostic testing and radiology except as outlined in 7.23.a.2.

3. Prescription medications and over-the-counter drugs and remedies.

4. Services or supplies otherwise covered or excluded under the Basic Benefit Schedule.

7.24 Preventive Care

a. Routine physical examinations. Scheduled routine physical examinations, including complete blood count (CBC), history and physical, urine analysis (UA), chemical profile, and stool hemocult, are covered according to the following schedule:

1. Pediatric (under age 19)

Infant (under age 2)	Eight well-baby exams in the first 24 months.
Early childhood (3 through 5 years)	One exam every year
Late childhood (6 through11 years)	One exam every 2 years
Adolescent (12 through 18 years)	One exam every year

2. Adult

19 through 40 years	One exam every 3 years
41 through 60 years	One exam every 2 years
Over 60 years	One exam every year

Physical Examinations do not include stress test, EKG, chest x-ray, or sigmoidoscopy unless Medically Necessary.

b. Immunizations and inoculations. Immunizations and inoculations routinely administered are covered. Immunizations for the purpose of travel are not covered. If your responsibility for services is an office call Copayment rather than a percentage of allowable charges, one immunization/inoculation Copayment equal to the office call Copayment is charged per immunization/inoculation visit. This Copayment is waived if an office call is billed along with the immunization/inoculation charge.

c. Family planning. Counseling and assessment for birth control are covered. Diaphragms and non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables are covered when provided in the doctor's office. These items, while covered under this Basic Benefit Schedule, are excluded under your Supplemental Prescription Benefits Schedule, if any.

d. Vision Screening Exams. Vision screening to determine the need for vision correction is covered. Eye examinations for refractions are not covered. All types of vision hardware and corrective appliances are excluded except as provided under Durable Medical Equipment and Medical Supplies of the Basic Benefit Schedule.

e. Circumcisions. Circumcisions for newborn male children are covered.

The deductible, if any, is waived for services covered under Article 7.24.

7.25 Sterilization. Male and female sterilization procedures are covered. Benefits are subject to payment of any applicable Copayments or Coinsurance. Reversal of voluntary infertility (sterilization) is not covered.

7.26 Colorectal screening. Colorectal cancer screening examinations and laboratory tests are covered for Members age 50 and over consistent with the guidelines or recommendations of the United States preventive services task force or the federal centers for disease control and prevention.

Additional Medically Necessary testing is covered at any age for Members who are at high risk for colorectal cancer, including but not limited to Members with a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis, or other predisposing factors.

Article 8 - Prior Authorization

8.1 The services requiring Prior Authorization are specified in this Basic Benefit Schedule. Except in the case of Emergency Medical Care, coverage for those services will be provided only if Prior Authorization has been obtained from us. Refer to Article 5 of the Group Medical and Hospital Service Agreement for further detail of the Prior Authorization process.

8.2 A Provider request for Prior Authorization of non-emergency services must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning continued length of stay.

8.3 You may request a referral for specialist services for an extended period of time if you have a complex or chronic medical condition.

8.4 In accordance with RCW 48.43.525, we will not retrospectively deny claims for services which were Prior Authorized at the time the care was rendered.

Article 9 - Exclusions and Limitations

All the following benefits, accommodations, care, services, equipment, medications or supplies are expressly excluded from coverage:

1. Any care deemed not Medically Necessary or not in accordance with accepted medical standards by the Medical Director; and any hospital or medical care services not specifically provided for in the Medical and Hospital Service Agreement or this Basic Benefit Schedule.

2. All services or supplies that exceed any maximum cost or time (days or visits) limitation imposed in this Schedule, the Copayment and Coinsurance Schedule, or any Supplemental Benefit Schedule.

3. Covered services and supplies for injuries or illnesses for which another person or entity is legally responsible or agrees to a settlement for the injury or illness. If we pay benefits before any such payments are made, reimbursement must be made in accordance with Article 15 - Right of Recovery in the Group Medical and Hospital Service Agreement.

4. Medical, surgical or other health care procedures, treatments, devices, products or services (collectively, "health care services") which are determined by us in our discretion to be Experimental or Investigational, and complications directly caused thereby.

5. Non-emergency services without a Prior Authorization, if Prior Authorization is required pursuant to Article 5 – Participating Providers and Article 8 – Prior Authorization.

6. Expenses for any condition or complication caused by any procedure, treatment, service, drug, device, product or supply excluded from coverage.

7. Services performed in connection with treatment to teeth or gums, upper or lower jaw augmentation or reduction, or orthognathic surgery, including treatment or internal or external Prosthetic Devices for disorders of the temporomandibular joint; all dental services and dentures except as specified under Article 7.17 TMJ, Article 7.18 Oral and Maxillofacial Services, Article 7.19 Dental Anesthesia, and Article 7.20 Dental Injury or for a child with a congenital anomaly.

8. Orthodontic services, except for treatment covered under Article 7.20 Dental Injury.

9. Custodial Care; respite care.

10. Eye refractions or examinations; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratotomy and clear lensectomy. Hearing screening and tests except as provided in Article 2.3 and 7.24.e, hearing aids, masking devices or other hearing devices or the fitting thereof. Also excluded are eyeglasses and all other types of vision hardware or vision corrective appliances and contact lenses except as provided in Article 7.9 and 7.10.d.

11. Corrective appliances and artificial aids; braces; disposable or non-prescription or over-the-counter supplies, such as ace bandages, splints, and syringes unless dispensed by a Participating Provider and except as provided in Article 7.9; exercise and hygiene equipment; support garments; electronic monitors; devices other than blood glucose monitors to perform medical tests on blood or other body substances or excretions; devices or equipment not exclusively medical in nature including but not limited to sauna baths, spas, elevators, light boxes, air conditioners or filters, humidifiers or dehumidifiers; orthopedic chairs and motorized scooters; devices or equipment which can be used in the absence of a medical need; or modifications to the home or motorized vehicles. Corrective shoes and arch supports including foot orthotics are excluded unless prescribed in the course of treatment for, or complications from, diabetes.

12. Cosmetic services, except for treatment covered under Article 7.18 Oral and Maxillofacial Services and Article 7.20 Dental Injury. All cosmetic or other services rendered to improve a condition which falls within the normal range of function.

    This Exclusion does not apply to Reconstructive Surgery that : (1) we determine to be Medically Necessary to repair a significant functional disorder as a result of illness or injury; or (2) is incident to a Medically Necessary mastectomy; or (3) is performed to repair congenital defects of a child.

13. Preparation and presentation of medical or psychological reports or physical examinations required primarily for your protection and convenience or for third parties, including but not limited to examinations or reports for school events, camp, employment, marriage, trials or hearings, licensing and insurance.

14. Immunizations and inoculations except as provided under 7.24 Preventive Care.

15. Payment for care for conditions that state or local law requires be treated in a public facility. All military service connected disabilities.

16. Diagnosis and treatment of infertility. Complications caused by treatment for infertility. Infertility is the failure of a couple during normal childbearing years to achieve conception after one or more years of regular sexual intercourse without practicing contraceptive measures. Sexual dysfunction that prevents successful intercourse may also be considered infertility. Infertility-related diagnosis and treatment includes but is not limited to:

a. Evaluation and/or treatment of an inability to conceive.

b. Evaluation and/or treatment of habitual abortion, including chromosomal analysis.

c. Assisted reproductive technologies and artificial insemination.

Semen analysis, documentation of normal ovulation function unless done as part of an endocrine evaluation for non-infertility indications, post-coital examination, and testing for patency of fallopian tubes is always considered infertility evaluation.

17. Reversal of voluntary infertility (sterilization). Procedures, services and supplies related to sex transformation, transsexualism or paraphilias (sexual deviations).

18. Diagnosis, treatment and rehabilitation services for any classification of obesity and eating disorders including counseling, diet supplements, weight loss surgery or complications caused by weight loss surgery. Services for obesity, including but not limited to morbid obesity, and eating disorders are excluded regardless of co-morbidities. Services for bulimia and anorexia are covered only as mental health benefits.

19. Personal comfort items, such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc.

20. Diagnosis and treatment for learning disorders, psychosocial problems, speech delay, conceptual handicap and developmental delay or dyslexia except as outlined in Article 7.22 for Members under age 7.

21. Speech generating devices: Augmentive and alternative communication devices or communicators. This exclusion does not include an artificial larynx for Members who have had a complete laryngectomy.

22. Rehabilitation therapy except as provided in Article 7.5 and 7.22.

23. Medications, surgical treatment or hospitalization for treatment of impotency; penile implants; services, devices, Prosthetic Devices, or aids related to treatment for any types of sexual dysfunction, congenital or acquired; sperm storage or banking.

24. Genetic engineering.

25. Recreational or educational therapy; non-medical self-help training.

26. Bone bank and eye bank charges.

27. Counseling or training in connection with family, sexual, marital, or occupational issues.

28. Orthoptics, pleoptics (visual therapy and/or training), visual analysis.

29. Services for which you would not be liable in the absence of our coverage. Services rendered by a person who resides in your home or by an immediate relative.

30. Any illness, condition or injury occurring in or arising out of the course of employment.

31. Court-ordered care, unless determined to be Medically Necessary and Prior Authorized by us. Psychiatric therapy as a condition of parole, probation or court order.

32. Outpatient prescription and over-the-counter drugs and medications. Prescriptions relating to an inpatient/outpatient confinement filled at a hospital pharmacy prior to discharge for use at home (take-home medications) except for prescriptions for a 24-hour supply or less, following an emergency room visit.

33. Diagnosis, treatment and rehabilitation services for injuries sustained while practicing for or competing in a professional or semi-professional athletic contest.

34. Programs for the specific intent of pain management.

35. Biofeedback for the treatment of vulvodynia, ordinary muscle tension, psychosomatic conditions, or for the management of chronic pain in pain rehabilitation programs.

36. Hair analysis.

37. Routine foot care, including treatment for corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes.

38. Growth hormone therapy.

39. Preventive and routine examinations, services, testing, and supplies, except as outlined in Article 2.1 and 7.24.

40. Services of a nutritionist, except for specific conditions such as diabetes, high blood pressure, and anemia.

Health Net Health Plan of Oregon
Washington PPO Plan
Group Medical and Hospital Service Agreement

Article 1 – Introduction

1.1 This Agreement is entered into between us and the Subscriber Group named on the attached Signature Sheet.

1.2 We are an authorized health care service contractor in the State of Washington.

1.3 Subscriber Group desires to make available prepaid comprehensive health care services to eligible persons who participate in its Health Benefit Plan.

1.4 In consideration of the mutual promises of the parties and the periodic payment to us of the required premiums and subject to the terms and conditions contained in this Agreement, we agree to provide Subscribers and their Enrolled Dependents with Medical and Hospital Services and other benefits specified in this Agreement.

1.5 It is agreed by the parties that this is not an indemnity health insurance contract but is an agreement to provide Subscribers and their Enrolled Dependents with health care benefits as specified by this Agreement. All interpretations of this Agreement shall be guided by such nature of this Agreement.

Article 2 – Definitions

The following terms, when used in this Agreement, are defined as follows:

2.1 "Adverse Benefit Decision" means any denial, reduction, termination, or failure to provide a payment or service (in whole or in part) when related to: (a) the determination of benefits available under the Agreement; (b) the determination of a Member's eligibility under the Agreement; (c) the application of utilization review and pre-authorization provisions under the Agreement; and (d) the application of experimental or investigational exclusions.

2.2 "Agreement" means this Medical and Hospital Service Agreement, all attached Benefit Schedules and Copayment and Coinsurance Schedules, any exhibits, supplements, addenda, attachments, amendments, endorsements, or riders. Additionally, employers will receive a Signature Sheet, a copy of their group application, and any information submitted as part of an application for this Agreement or for membership under this Agreement.

2.3 "Ambulatory Surgery Center" means a facility that performs outpatient surgery not routinely or customarily performed in a physician's or dentist's office, and is able to meet health facility licensure requirements.

2.4 "Anniversary Date" means an anniversary of the Effective Date as identified on the Signature Sheet of this Agreement.

2.5 "Benefit Schedule" means the attached exhibits identified as the Coinsurance Schedule or other Benefit Schedule(s) which set forth the medical, hospital and other benefits provided under this Agreement.

2.6 "Calendar Year" means the period of time beginning January 1 and ending December 31. Each succeeding January 1 will start a new Calendar Year.

2.7 “Chemical Dependency” means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

2.8 “Coinsurance” means the percentage of a Provider’s covered charge stated in the Copayment and Coinsurance Schedule or a Supplemental Benefit Schedule to be paid by Members directly to Providers for covered services.

2.9 “Contract Year” means the period of time beginning on the effective date of the Agreement and continuing for one year or until the Anniversary Date of the Agreement, whichever occurs earlier. Each Anniversary Date begins a new Contract Year.

2.10 “Copayment” means the fixed dollar amount stated in a Copayment and Coinsurance Schedule or a Supplemental Benefit Schedule to be paid by Members directly to Providers for covered services. The deductible is waived for services where the Member’s responsibility is a Copayment rather than Coinsurance. The office visit Copayment includes physician services only.

2.11 “Creditable Coverage” means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual Coverage (including student health plans); Medicaid; Medicare; State Children’s Health Insurance Program (SCHIP); TRICARE; Indian Health Service or tribal organization coverage; state high risk pool coverage; employer-provided self-funded health plans; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 90 days.

2.12 “Custodial Care” means care that does not require the continuing services of skilled medical or allied health professionals or that is designed primarily to assist a Member in activities of daily living, whether provided in an institution or in the home. Custodial Care includes but is not limited to medical care and services which can reasonably be provided to a Member by a medically non-licensed individual such as a parent, spouse, child or other resident of the home, help in walking, getting in and out of bed, bathing, dressing, use of the toilet or commode, feeding, preparation of special diets, and supervision of medications that are ordinarily self-administered.

2.13 “Dependent” means any member of a Subscriber’s immediate family who is one of the following:

a. The spouse of the Subscriber.

b. An unmarried child of the Subscriber from birth and extending up to the last day of the month in which that child becomes age 23, including a child who is the subject of a qualified medical child support order requiring the Subscriber to provide health coverage for the child. Proof of compliance with this requirement must be furnished annually.

“Child” means a natural child of the Subscriber, an adopted child of the Subscriber, or a stepchild of the Subscriber during the marriage of the Subscriber and the natural parent, but does not include foster children, wards, or children who are under temporary custody of the Subscriber or spouse. “Child” also does not include children of Dependents unless the Subscriber is a court-appointed guardian. Provided, however, that a child who is placed with a Subscriber for the purposes of adoption shall be considered a Dependent of the Subscriber as required by the laws of the State of Washington. Placement for adoption means the assumption and retention by a Subscriber or spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Coverage of any Dependent child of a Subscriber shall not be terminated by the child’s attaining the relevant limiting age if the child is and continues to be Disabled. Proof of disability must be furnished within 31 days of reaching a limiting age and not more frequently than annually after the first two years of continued coverage. We will not deny enrollment of a Child because the Child was: (a) born out of wedlock; (b) is not claimed on the parent’s federal tax return; or (c) does not reside with the parent or within our Service Area.

2.14 “Disabled” means, in the case of an adult person an individual who by reason of developmental disability, injury or illness is totally unable to perform the usual tasks in the work he/she was performing at the time of the developmental disability, injury or illness and is wholly unable to perform in any physical or mental capacity in his/her current occupation or is wholly unable to engage in the normal activities of a person of the same age and sex. A Dependent prior to his/her 23rd birthday will be considered Disabled when the Dependent is both (1) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (2) chiefly dependent upon the subscriber for support and maintenance. The determination of the Medical Director regarding the existence of a Disability will control, subject only to Article 10 – Rights of Members.

2.15 “Durable Medical Equipment” means equipment (a) which can withstand repeated use; (b) the only function of which is for treatment of a medical condition or for improvement of function related to the medical condition; (c) which is of no use in the absence of the medical condition; and (d) which is appropriate for home use.

2.16 “Effective Date” means the date of this Agreement as stated on the Signature Sheet. The date coverage is effective for individual Subscribers and Dependents is described herein.

2.17 “Eligible Employee” means an individual who works a minimum number of hours per week, as specified on the Group Application, at the business of the Employer and otherwise has a bona fide employee/employer relationship with the Subscriber Group. The term excludes individuals who work on a temporary or substitute basis or as an independent contractor.

2.18 “Emergency Medical Care” means otherwise covered health care services Medically Necessary to evaluate and treat an Emergency Medical Condition, provided in a Hospital emergency department.

2.19 “Emergency Medical Condition” means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

2.20 “Emergency Medical Screening Exam” means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

2.21 “Enrollment” or “Enroll” or “Enrolled” means the completion and signing of the necessary enrollment forms by or on behalf of an eligible person and acceptance by us.

2.22 “Exclusion Period” means a period during which no benefits shall be provided for specified transplant services until you have been covered under this Agreement for a period of 12 consecutive months. The Exclusion Period does not apply to a newborn or newly adopted child. Upon receipt of a certificate of Creditable Coverage, the Exclusion Period will be reduced by the length of Creditable Coverage under other Health Benefit Plans.

2.23 “Expedited Appeal” means any appeal for benefits under the Agreement where applying normal appeal consideration time periods could: (a) seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (b) subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the basis for the appeal, in the opinion of a physician with knowledge of the Member’s medical condition.

2.24 “Experimental” or “Investigational” means any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply which we have determined in our sole discretion, not to have been demonstrated as safe, effective, and medically appropriate for use in the treatment of an illness, injury, or condition at issue ("Illness") as compared with the conventional means of treatment or diagnosis. "Experimental or Investigational" also includes services, supplies, drugs, and procedures that we determine to be educational or the subject of a clinical trial.

In making this determination, we shall refer to evidence from the Washington medical community, which may include one or more of the following sources:

1. evidence from national medical organizations, such as the National Centers for Health Services Research;
2. peer-reviewed medical and scientific literature;
3. publications from organizations such as the American Medical Association;
4. professionals, specialists, and experts; and
5. written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device or medical treatment.

For us to determine that the drug, device, service or supply is not Experimental or Investigational, it must meet all of the following criteria:

1. If it is a drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), final FDA approval must have been obtained at the time the drug or device was furnished. Interim FDA approvals for a Phase I, II, or III trial, pre-market approval applications and Investigational exemptions are not sufficient. Our approval for drugs and devices which have been given final approval by the FDA will be limited to: (a) the uses and indications for which the drug or device was licensed or (b) uses and indications which We determine are recognized or approved in accordance with generally accepted professional medical standards in the Washington medical community as being safe, effective and medically appropriate for use in the treatment of the "Illness."
2. If it is a service or supply, it must be recognized or approved in accordance with generally accepted professional medical standards in the Washington medical community as being safe, effective and medically appropriate for use in the treatment of the "Illness" as compared to the conventional means of treatment or diagnosis. Any required approval of any federal government or agency, or any state government or agency, must have been obtained prior to the time of use.

Evidence will not be considered conclusive if the service or supply is: (a) the subject of ongoing Phase I, II, or III clinical trials; or (b) it is under study to determine maximum tolerated dose, toxicity, safety or medical appropriateness as compared with the conventional treatment or diagnosis; or (c) if its safety, effectiveness or medical appropriateness is the subject of substantial debate within the Washington medical community.

The fact that a physician or other medical professional or expert prescribes, orders, recommends, recognizes, or approves any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply does not in itself make the procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply non-Experimental or non-Investigational within this definition.

The fact that the service or supply is authorized by law or otherwise for use in testing, trials, or other studies on human patients shall not in itself make the service or supply non-Experimental or non-Investigational.

2.25 “Grievance” means a written or an oral complaint submitted by or on behalf of a covered person regarding: (a) Denial of health care services or payment for health care services; or (b) Issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

2.26 “Health Benefit Plan” means any Hospital expense, medical expense or Hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

2.27 "Home Health Care" means a program of care provided by a public agency or private organization or a subdivision of such an agency or organization which (a) is primarily engaged in providing Skilled Nursing Services in homes or places of residence of its patients; (b) is licensed according to applicable laws of the State of Washington and of the locality in which it is located or provides services; and (c) if the Member resides within the Service Area, has a written agreement with us as an agency or organization to provide Home Health Care to Members under this Agreement.

2.28 "Hospice" means a program provided by a public agency or private organization that is primarily engaged in providing services to terminally ill persons. The Hospice and its employees must be licensed in accordance with applicable state and local laws and certified by Medicare.

2.29 "Hospice Care" is care provided by a Hospice and designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in the patient's home.

2.30 "Hospital" means an institution which is either:

a. An institution which is primarily engaged in providing, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be located on its premises, under the supervision of a staff of Physicians and with 24 hour-a-day nursing services; or

b. An institution not meeting all the requirements of (a) above, but which is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or pursuant to Title XVIII of the Social Security Act as amended.

In no event shall the term "Hospital" include a convalescent nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, or nursing facility.

2.31 "Hospital Services" means those Medically Necessary services for inpatients and outpatients which are generally and customarily provided by acute care general Hospitals, and which are prescribed, directed, or authorized by a Physician in accordance with this Agreement. "Hospital Services" shall also include Medically Necessary services rendered in the emergency room and/or the outpatient department of any Hospital. Except for Emergency Medical Care, Prior Authorization is required for Hospital Services.

2.32 "Individual Practice Association" or "IPA" means a Physicians' group which has contracted with us as a Participating Provider.

2.33 "Initial Enrollment Period" means the 31 days following the date an individual first becomes eligible for coverage under this Agreement.

2.34 "Late Enrollee" means an individual who enrolls in a group Health Benefit Plan subsequent to the Initial Enrollment Period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a Late Enrollee if:

a. The individual applies for coverage during an open enrollment period;

b. A court has ordered that coverage be provided for a spouse or minor child under a covered Subscriber's Health Benefit Plan and request for enrollment is made within 31 days after issuance of the court order;

c. The individual is employed by a Group Subscriber who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an open enrollment period agreed upon by Group Subscriber and us;

d. The individual applies for coverage within 31 days after becoming eligible for a FHIAP (Family Health Insurance Assistance Program) subsidy; or

e. The department of social and health services determines that it is cost-effective to enroll a person eligible for medical assistance under chapter 74.09 in an employer-sponsored health plan for which he of she is otherwise eligible.

f The individual qualifies for Special Enrollment under Article 4.6

2.35 "Medical Director" means a Medical Director of our plan or his or her designee. A decision of the Medical Director which substantially affects a Member is subject to Article 10 – Rights of Members, and will be made in the exercise of the Medical Director's reasonable judgment, subject to all of the terms and conditions of this Agreement.

2.36 "Medical Services" means those Medically Necessary health care services which are performed, prescribed or directed by a Physician, except as expressly limited or excluded by this Agreement.

2.37 "Medically Necessary" means any health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or it's symptoms, and that are :

a. in accordance with generally accepted standards of medical practice;

b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and;

c. not primarily for convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas, and any other relevant factors.

Determination of Medical Necessity is done on a case by case basis. The fact that a provider of services has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a particular illness, injury, or sickness does not make the procedure or treatment Medically Necessary. The determination of the Medical Director regarding what is Medically Necessary will control, subject only to Article 10 – Rights of Members.

2.38 "Member" or "Enrollee" means any Subscriber or Dependent who satisfies all of the requirements of this Agreement, who has been Enrolled by us and for whom the current monthly premium has been received by us.

2.39 "Nonparticipating Provider" means any Provider who is not a Participating Provider at the time services are rendered to a Member.

2.40 "Participating Provider" means a licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, or other licensed or certified entity or person who has entered into a contract or other arrangement to provide health care services to Members of this PPO Plan with an expectation of receiving payment, other than deductibles, Coinsurance, and Copayments, directly or indirectly from us, and such contract or other arrangement is in effect at the time such services are rendered.

2.41 "Peer Review Committee" means the panel of Participating Physicians designated and appointed by an IPA and/or our Board of Directors.

2.42 "Physician" means any doctor licensed to practice medicine or osteopathy in Washington or in the state in which medical care is rendered.

2.43 “Pre-existing Condition” means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the three-month period preceding the enrollment date, which means the earlier of the first day of the Subscriber Group’s probationary period or the Member’s effective date of coverage. The enrollment date for a Late Enrollee is the effective date of coverage. Pregnancy is not a Pre-existing Condition. Genetic information does not constitute a Pre-existing Condition in the absence of a diagnosis of the condition related to such information. Treatment for phenylketonuria is not a Pre-Existing Condition.

2.44 “Prior Authorization” means written or oral approval obtained from us in advance of receiving specified medical treatment or supplies covered under this Agreement. Prior Authorization is not required for Emergency Medical Care.

a. A Prior Authorization issued by us shall be binding in accordance with its terms for 30 days, except that a Prior Authorization shall not be binding if:

1. The Prior Authorization specifies a date on which coverage terminates and services were obtained after that date; or

2. The Prior Authorization was obtained through misrepresentation.

In accordance with RCW 48.43.525, we will not retrospectively deny claims for services which were Prior Authorized at the time the care was rendered.

b. We will answer a request for Prior Authorization of non-emergency services within two working days.

c. A Physician will retain responsibility for recommendations related to whether a service or procedure, and where it is to be performed, is appropriate for treating a specific medical condition.

2.45 “Prosthetic Devices” means artificial substitutes that are required to replace all or any part of a body organ or extremity.

2.46 “Provider” means any licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, or other entity or person who is licensed or certified and is acting within the scope of his or her license to furnish health care services.

2.47 “Service Area” means the state of Oregon and the state of Washington.

2.48 “Signature Sheet” means the sheet attached to this Agreement and identified as such.

2.49 “Skilled Nursing Facility” has the same meaning as Extended Care Facility in Title XVIII of the Social Security Act and regulations but is limited to those facilities with a contract or other arrangement with us.

2.50 “Skilled Nursing Service” has the same meaning as Extended Care Service in Title XVIII of the Social Security Act and regulations except that it does not include a requirement of prior hospitalization; is interpreted as if all Members were covered under both parts of Title XVIII; and applies only to services performed, prescribed, or directed by a Participating Physician. “Post-Hospital Extended Care Service” has the same meaning as Title XVIII of the Social Security Act and regulations but applies only to services performed, prescribed, or directed by a Participating Physician.

2.51 “Stabilization” means that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur.

2.52 “Subscriber” means an Eligible Employee who meets all applicable requirements of this Agreement, who has Enrolled hereunder by submitting an enrollment application which has been approved by us, and for whom the monthly premium has been received by us in accordance with the terms hereof.

2.53 "Subscriber Group" means the entity, such as an employer, trust or association, sponsoring the health and welfare plan pursuant to which the benefits of this Agreement are made available to Eligible Employees. A Subscriber Group is limited to an entity that would, under Washington law, be eligible for a group medical policy or contract.

2.54 "Usual, Customary, and Reasonable" means the maximum allowable amount for a health care service, determined by us in our discretion on the basis of the fee usually charged by the Provider and data obtained by us regarding fees charged by Providers for the same service within the same geographic area. Amounts exceeding the Usual, Customary and Reasonable allowance are the Member's responsibility, and do not apply toward your out-of-pocket maximum.

2.55 "Women's Health Care Provider" means any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provides women's health care services; practitioners licensed under chapters 18.57A and 18.71A RCW when providing women's health care services; midwives licensed under chapter 18.50 RCW; and advanced registered nurse practitioner specialists in women's health and midwifery under chapter 18.79 RCW, practicing within the applicable lawful scope of practice.

Article 3 – Eligibility

3.1 To be eligible to Enroll as a Subscriber, a person must, at the time of Enrollment and throughout the term of this Agreement, be a Eligible Employee of the Subscriber Group and must meet the Subscriber Group's eligibility criteria.

3.2 To be eligible to Enroll as a Dependent, a person must be a Dependent of a Subscriber and must meet the Subscriber Group's eligibility criteria. A Dependent who is Enrolled as a Member will continue as an eligible Dependent through the last day of the month in which such Dependent ceases to meet the requirements of a Dependent.

3.3 Subscriber Group's eligibility criteria must be provided on the Group Application which is a part of this Agreement. If the criteria on an approved Group Application conflict with any eligibility criteria elsewhere in this Agreement, then the criteria on the application shall prevail.

3.4 During the term of this Agreement, Subscriber Group shall make no change in its eligibility standards for purposes of this Agreement unless such change is agreed to by us.

3.5 Any ineligible person Enrolled under this Agreement will not be entitled to benefits hereunder. We will refund to the Subscriber Group any premium paid for the ineligible person in excess of any benefits paid for the time the person was ineligible or for the last six months prior to discovery of the ineligibility, whichever is shorter (the "refund period"). We shall also be entitled to repayment from the ineligible person for the cost of benefits provided during the refund period in excess of the premium received by us for the ineligible person for that period. If the ineligible person was carried by Subscriber Group as a Subscriber, we shall also be entitled to repayment from the Subscriber Group for the cost of benefits provided during the refund period in excess of the premium received by us for the ineligible person during that period.

Article 4 - Enrollment and Effective Date

4.1 Initial Eligibility. Eligible Employees and/or their Dependents may Enroll by submitting a completed application form within 31 days of the first day of employment, transfer or the first day of eligibility for health benefits. Coverage shall become effective as specified on the Signature Sheet, provided that a completed application form and the required premium payment are received within 31 days of the person's first day of eligibility.

4.2 Open Enrollment. Eligible Employees and/or Dependents who do not Enroll when initially eligible may Enroll by submitting a completed application form during the open Enrollment period specified on the Signature Sheet.

4.3 Newborn Child. A newborn child of the Subscriber or the Subscriber's spouse will be covered as a Dependent for 21 days from the moment of birth. To continue coverage after 21 days, if an additional premium is

required, you must submit a written request to us to add the Dependent within 60 days of the birth, and pay any required premiums. If you do not notify us within 60 days when an additional premium is required, the Child will be considered a Late Enrollee.

4.4 Newly Adopted Child. Coverage for a newly-adopted Child, or a Child who has been placed for adoption with you and for whom the application procedures for adoption have been completed while your coverage is in effect, will be provided on the same basis as any other newly eligible Dependent. Placement for adoption means the assumption and retention by a Subscriber or spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. An adopted child shall not be considered a Dependent child for coverage purposes upon termination of such legal obligations. This coverage applies to children under the age of 18 years at the time of adoption.

You must submit a written request to us to add the Dependent within 60 days following the date of adoption or placement for adoption if an additional premium is required, and pay any required premium. If you do not notify us within 60 days when an additional premium is required, the Child will be considered a Late Enrollee.

4.5 Other Newly Eligible Dependents. A Subscriber may Enroll a newly eligible Dependent by submitting a completed application form within 31 days of attaining eligibility. Enrollment is effective on the day the Dependent becomes eligible.

4.6 Special Enrollment.

a. Loss of Other Coverage. An Eligible Employee and/or Dependents who previously declined coverage under this Agreement because of coverage under another Health Benefit Plan can Enroll in this Agreement by submitting a completed application form within 31 days of loss of such other coverage because of marriage, birth of a child, legal separation, divorce, death, termination of employment, reduction in hours of employment, discontinuation of employer contributions, attainment of a policy lifetime maximum, or exhaustion of COBRA continuation under such other group coverage. Enrollment is effective the first day of the following month.

b. Newly Acquired Dependents. An Eligible Employee and/or newly acquired Dependents can Enroll in this Agreement by submitting a completed application form within 31 days of marriage. Enrollment is effective the first day of the following month.

4.7 Late Enrollee. A person who does not Enroll during a period provided above is entitled to Enroll as a Late Enrollee upon submission of a completed application form at any time. Late Enrollees will be excluded from coverage for three months. Creditable Coverage will apply.

4.8 Subscriber Group shall notify us no later than the next billing cycle of any changes which may affect Member eligibility.

4.9 Subscriber Group shall require each Member to disclose to us at the time of Enrollment, at the time of receipt of covered services and supplies, and from time to time as requested by us, the existence of any other group coverage the Member may have, the identity of the carrier, and the group through whom the coverage is provided.

4.10 We shall have the right, at reasonable times, to examine the records of Subscriber Group and Subscriber Group's subcontractors, including payroll records, with respect to eligibility and monthly premiums under this Agreement. Subscriber Group shall have the right, at reasonable times, to examine our records pertaining to Subscriber Group with respect only to Enrollment, eligibility and receipt of monthly premiums under this Agreement.

Article 5 - Participating Providers

5.1 If a Member receives care from a Participating Provider, the Participating Provider is responsible for obtaining Prior Authorization on the Member's behalf, and the Member will not be responsible for the cost of the

services if Prior Authorization is not obtained. However, if a Member receives care from a Non-Participating Physician or other non-participating health care Provider without a required Prior Authorization, the Member is responsible for obtaining Prior Authorization and shall be responsible for the cost of those services. Failure of a Non-Participating Provider to obtain the Prior Authorization shall in no way relieve the Member of the financial responsibility for services received from that Non-Participating Provider.

5.2 Upon Enrollment, each Member will be issued a plan identification card. It is the Member's responsibility to present the card to each health care Provider at the time of service.

5.3 To ensure the maximum available benefits under this Agreement, Members should obtain all Medical Services from Participating Providers and in accordance with any Prior Authorization requirements, even when a Member expects payment to be made by another plan or a third party. Care furnished by a Non-Participating Provider is generally reimbursed at a lower level.

5.4 If a Member resides outside the Service Area and is unable to receive services from Participating Providers, the Member's Coinsurance for covered services will be at the Non-Participating Provider Level specified in the Coinsurance Schedule.

Article 6 - Delegation of Authority

6.1 Subscriber Group hereby delegates and vests with us the authority to determine, in our discretion, whether a treatment, procedure, or other type of health care is Medically Necessary or otherwise covered under the terms of this Agreement.

A Member has the right to file an Appeal under Articles 10.3 and 10.4 if dissatisfied with a determination. For these purposes, our final decision shall be the decision reached after all levels of our internal grievance procedure have been exhausted.

6.2 An Washington doctor of medicine or osteopathy shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the facility where they will be provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

Article 7 - Monthly Payments (Premiums)

7.1 The monthly premium rate is set forth on the Signature Sheet. If the State of Washington or any other taxing authority imposes upon us any new or additional tax or license fee which is levied upon or measured by premium, by our gross receipts, or by any portion of either, then we may amend this Agreement to increase the premium by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent, effective as of the date stated in a notice sent to Subscriber Group. The effective date of such a premium increase shall not be earlier than the date of the imposition of such tax or license fee increase. We shall also have the right to change the premium as of any date that the extent or nature of the risk under this Agreement is changed by amendment to this Agreement or by reason of any change mandated by law or regulation.

7.2 Each monthly premium shall be calculated on the basis of our records reflecting the number of Subscribers and Dependents in each premium classification, as set forth on the Signature Sheet, at the time of calculation and at the premium rate then in effect. Subscriber Group shall submit to us, on behalf of each Subscriber and Enrolled Dependents, the entire amount due, on or before the first day of the month for which coverage is provided. Subscriber Group assumes responsibility for collection of the contributory portion of the premium, if any, from each Subscriber.

7.3 Only Members for whom the premium is actually received shall be entitled to benefits, and then only for the period to which such premium is applicable. If the required premium for the Agreement is not received within 15 days of the due date, the Agreement shall terminate automatically. Thereafter, the Agreement will be reinstated only by renewed application and re-enrollment in accordance with all requirements of this Agreement.

7.4 The total amount paid monthly under this Agreement may change from time to time to reflect any change in the status of a Member or any change in the type of membership applicable to the Member (single, two party or family) or any change in state or federal benefit mandates.

7.5 Subscriber Group shall provide us with notice of changes in eligibility and enrollment within 30 days of the effective date of such changes. At our option, retroactive adjustments for premium may be made for any additions or terminations of Members and changes in coverage classification not reflected in our records at the time the monthly premium is calculated by us. However, in no event shall we refund to a Subscriber Group any premiums paid for a Member by Subscriber Group if the request for such refund is made later than 60 days after our receipt of payment for said retroactively terminated Member.

7.6 We reserve the right to change the premium rates and any other provisions of this Agreement effective at renewal on at least 30 days written notice before the renewal to the Subscriber Group. The 30 day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law.

Article 8 - Exclusions and Limitations

8.1 Benefits provided by this Agreement may be revoked or modified. No Member acquires a vested right to continue to receive a benefit as set forth in this Agreement on or after the effective date of any revocation or change to such benefit. A Member's right is to receive only such benefits as are expressly provided for and in effect on the date of each treatment. Upon termination of this Agreement or a Member's coverage under this Agreement, a Member's right to continued benefits consists solely of those benefits expressly set forth in Article 11 – Federal Continuation of Coverage and Article 12 – Washington State Conversion of Coverage.

8.2 Members are entitled to receive benefits subject to the exclusions and limitations as stated in any provision of this Agreement.

8.3 Benefits are available only as Medically Necessary.

8.4 Coverage for the services of a Nonparticipating Provider is limited to and based on a Usual, Customary and Reasonable fee.

8.5 Members who are treated by a Provider without a Prior Authorization, if required pursuant to Article 8 of the Basic Benefit Schedule, will have any and all such claims denied by us.

8.6 All benefits, exclusions and limitations set forth in the attached Benefit Schedules are incorporated herein by this reference.

8.7 To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of this Agreement, we are required only to make a good faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. For purposes of this Article, an event is not within our control if we cannot exercise influence or dominion over its occurrence.

8.8 Written notice of claim for Nonparticipating Provider benefits must be given to us within 90 days after the date of treatment or as soon as medically possible, but in no event later than one year from the date of treatment unless the Member is legally incapacitated throughout that year. If a Member is hospitalized at a Hospital that is a Nonparticipating Provider, the Member shall or shall cause the Hospital or the Subscriber to notify us by telephone of the hospitalization on the first business day after the admission or in the case of Emergency, as soon as medically possible. In the event that a Member is unable to personally contact us or is unable to instruct some other person to do so, the notification period will not begin until such time as the Member is again able to notify us. If a Member is conscious and able to communicate with others, he or she shall be deemed capable of notifying us.

8.9 Any complaint or grievance brought to recover on this Agreement shall be limited to the complaint and grievance procedure under Article 10 – Rights of Members. No complaint or grievance, including but not limited to complaints regarding denial of claims for payments or for services, may be submitted more than 180 days after the date of the denial notice.

8.10 Pre-existing Conditions.

a. Services for a Pre-existing Condition will be covered after a three-month Pre-existing Conditions waiting period has been satisfied.

b. The Pre-existing Conditions waiting period begins on the Member's effective date of coverage, which means the earlier of the first day of the Member's probationary period or the Member's effective date of coverage, and ends three months after the effective date of coverage.

c. Upon receipt of a certificate of Creditable Coverage, the waiting period will be reduced by the length of Creditable Coverage under other Health Benefit Plans that are not preceded by a break in coverage of 90 days or more. We will give enrolling Members written notice of our determination of any Pre-Existing Conditions waiting period that applies to a Member.

d. If the Subscriber Group offers Eligible Employees a choice of health coverage under either a federally-qualified HMO plan or this plan, an Employee transferring coverage from the HMO plan to this plan during an open enrollment period will not be subject to the waiting Period under this Agreement.

e. The Pre-Existing Conditions waiting period does not apply to a newborn child.

f. The Pre-Existing Conditions waiting period does not apply to a newly adopted child.

g. The three-month Pre-existing Condition waiting period does not apply to a Late Enrollee who has been excluded from coverage for three months.

8.11 Any benefit limitation or other dollar amount that is calculated on an annual basis hereunder shall be calculated on the basis of a Calendar Year.

Article 9 – Termination

9.1 This Agreement is renewable with respect to all Members at the option of the Subscriber Group except:

a. For nonpayment of the required premiums by the Subscriber Group.

b. For fraud or misrepresentation by the Subscriber Group, or with respect to the coverage of a Member by the Member or the Member's representative.

c. For noncompliance with the minimum participation or contribution requirements shown on the Signature Sheet;

d. For violation of our published policies that have been approved by the Insurance Commissioner;

e. When the policy is materially breached;

f. If upon written approval from the Insurance Commissioner, we cease to offer this particular policy form;

g. If we cease to offer coverage in the group market under which the policy is issued;

h. If we are withdrawing from a service area or from a segment of a service area because we have demonstrated to the Insurance Commissioner that our clinical, financial or administration capacity to serve existing Members would be exceeded.

i. When the Insurance Commissioner orders us to discontinue coverage in accordance with procedures specified or approved by the Insurance Commissioner upon finding that the continuation of the coverage would not be in the best interest of the Members or would impair our ability to meet contractual obligations.

j When, in the case of a group Health Benefit Plan that delivers covered services through a specified network of health care Providers, there is no longer any Member who lives or works in the service area of the provider network.

k. When, in the case of a Health Benefit Plan that is offered only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

If we discontinue this particular policy form or cease to offer coverage in the group market, we will provide notice as required by the Insurance Commissioner.

9.2. We may modify this Agreement at the time of renewal on at least 30 days written notice before the renewal to the Subscriber Group. The modification is not a discontinuation of this Agreement under 9.1.f or 9.1.g above. Written notice of modifications will be given to Subscriber Group at least 30 days prior to the effective date of the renewal. The 30-day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law.

9.3 Notwithstanding any provision of Article 9.1 to the contrary, we may rescind an Agreement for fraud, material misrepresentation or concealment by a Subscriber Group and the coverage of a Member may be rescinded for fraud, material misrepresentation or concealment by the Member.

9.4 In the event of termination of this Agreement on one of the grounds specified in this Agreement, termination will be effective as to the Subscriber Group and all Subscribers and Enrolled Dependents irrespective of whether monthly premiums have been received for periods beyond the termination date. However, in no event will this Agreement continue beyond the last day of the month for which monthly premiums have been received. Premium will be charged and collected for any period between the date through which premiums are paid and the termination date. If the Agreement is to terminate due to the required premium not paid when due, we will provide a written notice to the Policyholder, specifying the last date the premiums may be paid (no less than 10 days from the date of the notice) in order to reinstate the Agreement.

9.5 Coverage under this Agreement for a Member also will terminate on 30 days’ written notice: if (a) the Member commits insurance fraud as defined by the state of Washington (b) the Member knowingly permits another to use his or her plan identification card or has otherwise misused our plan; or (c) the Member has repeatedly failed to comply with this Agreement.

9.6 Coverage under this Agreement for a Member will also terminate on 30 days’ written notice: (a) if a Member knowingly presents a claim for a payment that falsely represents that the services or supplies were Medically Necessary in accordance with professionally accepted standards; (b) if a Member knowingly makes a false statement or false representation of a material fact to us for our use in determining rights to a health care payment; and (c) if the Member conceals the occurrence of any event affecting his or her initial or continued right under this Agreement or conceals or fails to disclose any information with intent to obtain services, supplies, or payment to which the Member or any other person is not entitled. We shall have the right to obtain a refund from the Member for all Medical Services paid for by us which were not legitimately eligible for coverage under this Agreement.

9.7 After the effective date of a termination pursuant to this Agreement, neither we nor the Participating Providers shall have any further obligation to provide care for the condition under treatment and no claim shall be paid by us for treatment arising after such termination date.

9.8 The membership of a Subscriber and all Dependents shall terminate in the event that the Subscriber leaves employment with the Subscriber Group or otherwise becomes ineligible, unless the Subscriber or any

Dependent continues or converts his or her membership in accordance with Article 11 – Federal Continuation of Coverage and Article 12 – Washington State Conversion of Coverage.

9.9 Except as expressly provided in this Article, all rights to benefits hereunder shall cease as of the effective date of termination.

9.10 We shall notify Subscriber Group by mail on a form that complies with applicable law within 10 days after this Agreement is terminated and not replaced by the Subscriber Group. This provision shall apply when an employer terminates participation in a multiple employer trust as well as in the event of termination of this Agreement when held by a multiple employer trust. If notice is not given as required by this Article, coverage shall continue from the date notice should have been provided until the date notice is received and premiums for that period shall be waived.

9.11 We will issue certificates of Creditable Coverage to Members whose coverage under this policy or COBRA or state continuation terminates. If a Member's coverage under this Agreement ceases before such Member's coverage under any health plan sponsored by Subscriber Group ceases, we will provide sufficient information to Subscriber Group to enable a Certificate of Creditable Coverage as to this Agreement to be provided by Subscriber Group after such Member's coverage under all health plans sponsored by Subscriber Group ceases.

9.12 The Subscriber Group may voluntarily terminate this Agreement for any reason upon 30 days written notice to us. When the group coverage is terminated by the Subscriber Group and replaced by other group coverage, no notice of termination will be given to the Member by us. If the group coverage is not replaced by other group coverage, notice of the termination will be provided to the Members through the offer of conversion coverage as outlined in Article 12.

Article 10 - Rights of Members

10.1 We shall have access to information from medical records of Members and information received by Physicians in the course of the Physician/patient relationship and the right to use such information as is reasonably necessary in connection with our administration of this Agreement, for records review incident to any peer review, quality assurance program or utilization review program. All provisions of law or professional ethics forbidding, restricting or treating as privileged or confidential such information are waived by or on behalf of each Member hereunder by acceptance of the benefits of this Agreement, and Members shall sign any specific releases necessary to effect this provision. Except as provided above, all such information shall be confidential and shall not be disclosed except as allowed by federal and state law.

Right to Limit Disclosure of Health Information

a. We will limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual. Disclosure of information under this provision will be limited consistent with the individual's request, such as a request for the us to not release any information to a spouse to prevent domestic violence.

b. We will not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, chemical dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a Subscriber or certificate holder, if the individual who is the subject of the information makes a written request. In addition, we will not require an adult individual to obtain the Subscriber's or other covered person's authorization to receive health care services or to submit a claim.

c. We will recognize the right of any minor who may obtain health care without the consent of a parent or legal guardian pursuant to state or federal law, to exclusively exercise rights granted under this section regarding health information; and

d. We will not disclose any nonpublic personal health information related to any health care service to which the minor has lawfully consented, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or other covered person, without the express authorization of the minor. In addition, we will not require the minor to obtain the Subscriber's or other covered person's authorization to receive health care services or to submit a claim as to health care which the minor may obtain without parental consent under state or federal law.

e. When requesting nondisclosure, the individual shall include in the request:

(1) His or her name and address;

(2) Description of the type of information that should not be disclosed;

(3) In the case of reproductive health information, the type of services subject to nondisclosure;

(4) The identity or description of the types of persons from whom information should be withheld;

(5) Information as to how payment will be made for any benefit cost sharing;

(6) A phone number or e-mail address where the individual may be reached if additional information or clarification is necessary to satisfy the request.

10.2 A Member may not be canceled or non-renewed on the basis of the status of his or her health or health care needs, provided however, that this paragraph shall not negate, waive, alter or otherwise change any other provisions of this Agreement.

10.3 Grievances and Appeals.

A Member is always encouraged to promptly contact the Customer Contact Center whenever there is a question, inquiry or a complaint about availability or delivery or quality of health care services, coverage denial based on Medical Necessity or experimental, a claim or Adverse Benefit Decision, or any other specific problem arising under this Agreement. If the problem is not resolved at that level, a Member has the Grievance and Appeals rights described below. We will assist a Member in filing a Grievance when he or she has a complaint and asks for help to put it in writing.

We will provide written notice to a Member, or his or her designated representative, and the Member’s Provider, of our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility.

Written notice will explain our decision and the supporting coverage or clinical reasons; and our appeal process, including information, as appropriate, about how to exercise the Member’s rights to obtain a second opinion, and how to continue receiving services.

We will process as an appeal an Member’s written or oral request that we reconsider: (a) our resolution of a complaint made by a Member; or (b) our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. We do not require that an Member file a complaint prior to seeking appeal of a decision.

To process an appeal, we will:

a. Provide written notice to the Member when the appeal is received;

b. Assist the Member with the appeal process;

c. Make our decision regarding the appeal within 14 days of the date the appeal is received, unless we notify the Member that an extension is necessary to complete the appeal. The extension will not go

beyond 30 days of the date the appeal is received without the informed written consent of the Member. The decision regarding an Expedited Appeal will be made within seventy-two hours of the date the appeal is received;

d. Cooperate with a representative authorized in writing by the Member;

e. Consider information submitted by the Member;

f. Investigate and resolve the appeal; and

g. Provide written notice of our resolution of the appeal to the Member and, with the permission of the Member, to the Member's Provider. The written notice will explain our decision and the supporting coverage or clinical reasons and the Member's right to request Independent Review of our decision.

10.4 Independent Review Process

A Member may seek review by a certified independent review organization of our decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting our grievance process and receiving a decision that is unfavorable to the Member, or after we have exceeded the timelines for grievances provided above, without good cause and without reaching a decision.

We will provide to the appropriate certified independent review organization, not later than the third business day after the date we receive a request for review, a copy of:

a. Any medical records of the Member that are relevant to the review;

b. Any documents used by us in making the determination to be reviewed by the certified independent review organization;

c. Any documentation and written information submitted to us in support of the appeal; and

d. A list of each Physician or health care Provider who has provided care to the Member and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in our custody may be provided to an independent review organization, subject to rules adopted by the Insurance Commissioner of the state of Washington.

The medical reviewers from a certified independent review organization will make determinations regarding the Medical Necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for a Member. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. The certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the Agreement. Medical reviewers may override our Medical Necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both us and the Member, or his or her representative.

We will timely implement the certified independent review organization's determination, and will pay the certified independent review organization's charges.

When a Member requests independent review of a dispute, and the dispute involves our decision to modify, reduce, or terminate an otherwise covered health service that a Member is receiving at the time the request for review is submitted and our decision is based upon a finding that the health service, or level of health service, is no longer Medically Necessary or appropriate, we will continue to provide the health service if requested by the Member until a determination is made. If the determination affirms our decision, the Member will be responsible for the cost of continued health service.

10.5 Review of Investigational or Experimental Therapies

We do not cover Experimental or Investigational drugs, devices, procedures or therapies.

In determining whether services are Experimental or Investigational, We will consider whether the services are in general use in the medical community of the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular Illness or disease, and whether they are proven to be safe and efficacious.

When we deny a request for benefits or do not allow Prior Authorization of a service, whether made in writing or through other claim presentation or set out in the Agreement, because of an Experimental or Investigational exclusion or limitation, we will do so in writing within twenty working days of receipt of a fully documented request. We may extend the review period beyond twenty days only with the informed written consent of the Member. The denial letter will identify by name and job title the individual making the decision and fully disclose:

a. The basis for the denial of benefits or refusal of Prior Authorization of services;

b. The procedure through which the decision to deny benefits or to refuse the Prior Authorization services may be appealed;

c. What information the Member is required to submit with the appeal; and

d. The specific time period within which we will reconsider its decision.

A final determination will be made and provided to the Member in writing within 14 working days of receipt of the fully documented appeal, unless we notify the applicant that an extension is necessary. We may extend the review period beyond 30 days only with the informed written consent of the Member. An appeal will be expedited if the Member's Provider or our Medical Director determines that following the appeal response, timelines could seriously jeopardize the applicant's life, health, or ability to regain maximum function. The decision regarding an expedited appeal will be made within 72 hours.

The appeal will be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

The appeal will be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse Prior Authorization of services.

When the initial decision to deny benefits or to refuse Prior Authorization of services is upheld upon appeal, the written notice will set forth;

a. The basis for the denial of benefits or refusal to Prior Authorization of services; and

b. The name and professional qualifications of the person or persons reviewing the appeal.

10.6 A Member aggrieved by any action by us must first exhaust the grievance procedure as set forth in Article 10.3.

10.7 Any legal action arising out of this Agreement must be filed in the state of Washington.

10.8 Upon the request, we will provide any of the following information in written form:

a. Any documents, instruments, or other information referred to in the medical coverage Agreement;

b. Procedures for obtaining Prior Authorization for health care services;

c. A description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between us and a provider or network;

d. Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

e. An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan;

f. A copy of our grievance process for claim or service denial and for dissatisfaction with care; and

g. Accreditation status with one or more national accreditation organizations, whether we track health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

Article 11 - Federal Continuation of Coverage

11.1 Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”)

a. If Subscriber Group is required to offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) and any regulations

thereunder, as now in effect or as amended from time to time, then we shall provide such coverage to Members, but only to the extent Subscriber Group is required by federal law to offer such coverage. All provisions of this Agreement not expressly superseded by COBRA shall apply to such COBRA continuation coverage.

b. Subscriber Group is solely responsible for (a) assuring compliance with COBRA; (b) giving Members timely notice, in accordance with COBRA, of their continuation coverage option; (c) notifying us within 15 days of a Member’s election to continue coverage and the applicable maximum coverage period; and (d) notifying us of any event which terminates Subscriber Group’s obligation to provide the Member with COBRA continuation coverage before the end of the maximum coverage period.

c. A Member must apply for COBRA continuation coverage within 60 days of the termination date of coverage, or the date the Member receives specific notice of his or her COBRA continuation coverage rights, whichever is later.

d. If Subscriber Group fails to give the Member notice of any COBRA continuation rights or to give us notice of any COBRA election, each within the time stated in Article 11.1.b above, we shall be entitled to charge Subscriber Group, and Subscriber Group shall pay the greater of (a) charges for Medical Services incurred by the Member prior to notice to us of the Member’s exercise of COBRA rights or (b) the applicable premium amount for coverage retroactive to the date of the Member’s qualifying event under COBRA. In any event, we will provide COBRA continuation coverage only for the minimum period required to enable Subscriber Group to meet our obligations under COBRA and, for purposes of this Article, such period will always begin on the date of the Member’s qualifying event. If we, in the exercise of reasonable judgment, determine that Subscriber Group willfully failed to give timely notice to a Member of any required COBRA continuation rights, we may refuse to provide COBRA continuation coverage to the Member.

e. The cost of COBRA continuation coverage will be 102 percent of the applicable group rate (including any portion previously paid by Subscriber Group), except where COBRA continuation coverage has been extended due to disability in which case the cost will be 150 percent of the applicable group rate for the period of extension.

f. The provisions of this Article will terminate if this Agreement terminates. Subscriber Group's violation of its obligations under Article 11.1 shall constitute grounds for termination of this Agreement.

11.2 The Family and Medical Leave Act of 1993 (FMLA).

If your Employer is subject to the requirements of The Family and Medical Leave Act of 1993 (FMLA), you may be eligible to continue coverage during a family leave. Consult your Employer for details.

Article 12 - Washington State Conversion Coverage

1. You may be eligible to apply for medical coverage under our conversion plan for you and your then covered Dependents, if any, if you lose coverage under this Agreement because:

    a. the Agreement terminates; or

    b. your coverage under this Agreement, or under any continuation option, ends.

2. Dependents are entitled to Conversion rights individually when:

    a. their benefits terminate on account of your death or divorce;

    b. a Dependent Child's benefits terminate because such Child marries or attains the limiting age for eligibility as a covered Dependent;

    c. the Subscriber is not eligible for a conversion plan due to misconduct; or

    d. coverage under any continuation option ends.

3. Conversion coverage will be provided under the forms and at the premium rates being offered by us at that time for medical conversion plans, based on the age and the amount of coverage applied for. Each person entitled to a conversion policy may elect a lesser form of coverage. The effective date of the conversion coverage will be the day after the coverage under this Agreement ends.

4. Conversion coverage must be applied for, in writing, to us, and the first premium paid to us within 31 days after coverage under this Agreement ends.

5. There are no conversion options available to any Member when:

    a. the Member is eligible for federal Medicare coverage or is covered under any other group plan, policy, contract, or agreement providing benefits for hospital or medical care; or

    b. the Member is eligible to obtain other similar group coverage within 31 days.

Article 13 - Coordination of Benefits

13.1 This Coordination of Benefits provision applies when a covered Subscriber or a covered dependent has health care coverage under more than one plan. If you are covered by more than one health benefit plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you.

13.2 The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

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

a. Plan includes: group, individual or blanket disability insurance contracts and group or individual contract issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care ; and Medicare or any other federal governmental plans, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

13.5 "This plan" means, in a Coordination of Benefits provision, the part of this agreement that provides benefits for health care expenses to which the Coordination of Benefits provision applies and which may be reduced because of the benefits of other plans. Any other part of this agreement providing health care benefits is separate from this plan. This agreement may apply one Coordination of Benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefits provision to coordinate other benefits.

13.6 The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the highest allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an allowable expense under this plan. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

13.7 "Allowable expense" means a health care expense, including deductibles, coinsurance and Copayments, but excluding pharmacy or vision care expenses, that is covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense and a benefit paid. An expense that is not covered by any of the plans covering the person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

a. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

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

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

13.10 Order of Benefit Determination Rules. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan. The benefits of this plan may be reduced when under the order of benefit determination rules; another plan determines its benefits first.

Except as provided in the paragraph below, a plan that does not contain a coordination of benefits provision that is consistent with this Article is always primary unless the provision of both plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of the basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.

a. In general, when there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan unless: (1) the other plan has rules coordinating its benefits with those of this plan; and (2) both those rules and this plan's rules as set forth in Article 13.10.b below require that this plan's benefits be determined before those of the other plan.

b. This plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the plan that covers the person other than as a Dependent, for example as an employee, Member, Subscriber or retiree. The benefits of the plan which covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, Member, Subscriber or retiree is the secondary plan and the other plan is the primary plan.

2. Dependent Child covered under more than one plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan the order of benefits is determined as follows:

a). For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year; but

2. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period.

b). For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rules applies to plan years commencing after the plan is given notice of the court decree.

2. If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for the health care expenses, the plan of the parent assuming financial responsibility is primary;

3. If a court decree states both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Article13.10.b.2.a) of this Section shall determine the order of benefits;

4. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Article 13.10.b.2.a) of this Section shall determine the order of benefits; or

5. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) first the plan of the parent with custody of the child;

(ii) then, the plan of the spouse of the parent with the custody of the child;

(iii) then, the plan of the parent not having custody of the child;

(iv) finally, the plan of the spouse of the parent not having custody of the child.

c). For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Article 13.10.b.2.a.) or 13.10.b.2.b.) of this Section shall determine the order of benefits as if those individuals were the parents of the child.

3. Active/Inactive Employee. The benefits of a plan which covers a person as an active employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as an inactive employee who is laid off or retired (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rules does not apply if Article 13.10.b.1 of this Section can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or federal law is covered under another plan, the plan covering the person as an employee, Member, Subscriber, or retiree or covering the person as a Dependent of an employee, Member, Subscriber, or retiree is the primary plan and the COBRA or state of other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if Article 13.10.b.1 of this Section can determine order of benefits.

5. Longer/Shorter Length of Coverage. If none of the pervious rules determines the order of benefits, the benefits of the plan which covered the employee, Member, Subscriber or retiree longer are determined before those of the plan which covered that person for the shorter time.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shall be shared equally between the plans meeting the definition of plan in Article 13.3 of this Section. In addition, this plan will not pay more than it would have paid had it been the primary plan.

13.11 Effect on the Benefits of This Plan. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make the payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim total allowable expense is the highest allowable expense of the primary plan or the secondary plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

13.12 Right to Receive and Release Necessary Information. Certain facts are needed to apply these coordination of benefits provisions. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to pay the claim.

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

13.14 Right of Recovery. We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Coordination of Benefits provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Contact your State Insurance Department for questions about Coordination of Benefits.

Article 14 – Medicare

In certain situations, this Agreement is secondary to Medicare. This means that when a Member is enrolled in Medicare and this Agreement at the same time, Medicare pays benefits for covered services first and we pay second, in accordance with federal law.

Article 15 – Right of Recovery

If we pay or arrange for a Member to receive covered services and supplies for injuries or illnesses for which another person or entity is legally responsible or agrees to a settlement for the injury or illness (the "Responsible Party"), then we or our agent is entitled to recover in full from the Responsible Party for the amount paid by us. The Member agrees:

1. To cooperate with us or our agent and do whatever is reasonably necessary to assist it to secure its rights;

2. That we or our agent has a lien on any recovery, settlement or judgment which may be had from or against a Responsible Party to the extent that it has made payment for covered services and supplies but only after the Member has been fully compensated;

3. To pay from any recovery, settlement or judgment (and the Member hereby authorizes his or her attorney to pay from any recovery, settlement or judgment), any and all amounts to which we or our agent is entitled under this section, unless otherwise agreed to by us or our agent in writing;

4. To promptly give any and all written directions, authorizations and assignments as are requested by us or our agent to assist in accomplishing or confirming the above;

5. That the benefits under this Agreement will be reduced if a Responsible Party has reimbursed a Member or paid for services which we would have covered as part of that benefit; and

6. To do nothing to prejudice our rights.

In exercising our Right of Recovery, we will not attempt to recover from the Member unless the Member has been made whole by the responsible party.

Article 16 - Independent Agents

16.1 The relationship between Subscriber Group and a Subscriber is that of plan sponsor and participant and is defined by the Group's health and welfare plan. We have no involvement in that relationship. The relationship between Subscriber Group and us is that of purchaser and seller and is entirely governed by the provisions of this Agreement. In addition, Subscriber Group acts as the agent of those Eligible Employees who are Subscribers with respect to all terms and provisions of this Agreement. Because the Subscriber pays the premium to us indirectly through his or her agent, the Subscriber Group, the relationship between a Subscriber and us is also that of purchaser and seller and is entirely governed by the provisions of this Agreement.

16.2 The relationship between us and Participating Providers is that of independent contractors. Participating Providers are independent professionals who operate their own offices and business, make their own medical decisions, and provide services to entities and patients other than us and our Members. Participating Providers agree to methods and rates of payment from us, concurrent and retrospective review by us of Medical Services provided to Members, and our medical management procedures.

16.3 The fact that Members and Participating Providers each have contractual relationships with us does not prevent a Member from obtaining nor a Participating Provider from providing services that are not covered by us. We have no direct control over the examination, diagnosis or treatment of a Member. We do perform medical management, including but not limited to case review for purposes of determining coverage, consultation with Providers regarding Prior Authorization, and concurrent and retrospective review of Medical Services provided to Members. The purpose of our medical management procedures is to encourage the lowest cost method of treating a Member which, based upon the Medical Director's sole judgment of the prevailing standards of medical treatment, meets the needs of the Member. These procedures are not intended to ration care or limit care to methods not appropriate to treat a Member's condition. These procedures are not intended to create a Physician/patient relationship or to replace the relationship between a Member and his or her Physician. A Member is always entitled to obtain, at his or her own expense, services not covered under the terms of this Agreement.

16.4 Except as outlined in Article 17.28, the Subscriber Group agrees to indemnify and hold us and our directors, officers and employees harmless against any loss and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses including attorneys' fees resulting from or arising out of the willful misconduct or dishonest, fraudulent, reckless, unlawful, or negligent acts or omissions of the Subscriber Group, any of its directors, officers, or employees or any Members enrolled under this Agreement, except to the extent that

such losses, claims, lawsuits, settlements, judgments, costs, penalties, or expenses result from the misconduct or dishonest, negligent, unlawful, reckless, or fraudulent act on the part of us or any of our directors, officers, employees, or parent, subsidiary, or otherwise affiliated entities.

16.5 We shall use ordinary care in the exercise of our power and in the performance of our obligations under this Agreement.

16.6 We agree to indemnify and hold harmless the Subscriber Group, its officers, and employees against any loss and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses including attorneys' fees resulting from or arising out of the willful misconduct or dishonest, fraudulent, reckless, unlawful, or negligent acts or omissions of us or any of our directors, officers, or employees, or parent, subsidiary, or other affiliated entities except to the extent that such losses, claims, lawsuits, settlements, judgments, costs, penalties and expenses result from the misconduct or dishonest, fraudulent, reckless, negligent or unlawful acts or omissions of the Subscriber Group, its directors, officers or employees or any Members enrolled under this Agreement.

Article 17 – Miscellaneous

17.1 By this Agreement, Subscriber Group makes our coverage available to all eligible persons. By electing medical and hospital coverage pursuant to this Agreement, or accepting benefits hereunder, all Members legally capable of contracting agree to all terms, conditions, and provisions hereof. This Agreement may be amended, modified, or terminated by mutual agreement between us and Subscriber Group without the consent or concurrence of any Member. Any modification or amendment must be in writing and signed by us. We may submit any proposed amendment or modification in writing to Subscriber Group. If Subscriber Group does not reject the proposed amendment or modification in writing within 30 days, it shall be deemed to be agreed to by the Subscriber Group and shall be effective as an amendment or modification, as the case may be, on the 31st day following such submission.

17.2 Members shall complete and submit to us forms as we may reasonably request.

17.3 Cards issued by us to Members are for identification only. Possession of our identification card confers no right to service or other benefits. The holder of our identification card must be a Member on whose behalf all amounts under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not entitled shall be charged at the usual rates of the Provider. If any Member permits the use of his or her plan identification card by any other person, such card may be reclaimed by us, and all rights of such Member and his or her Dependents may be terminated without notice at our election. Such Member shall be liable to us for all associated costs.

17.4 We may adopt reasonable policies, procedures, rules and interpretations not inconsistent with this Agreement to promote orderly and efficient administration of this Agreement.

17.5 Any notice under this Agreement shall be given by the U.S. mail, postage paid, addressed as follows:

a. To us at 13221 SW 68th Parkway, Tigard, Oregon 97223;

b. To Member at the address of record;

c. To Subscriber Group at the address indicated on the Signature Sheet.

17.6 This Agreement constitutes the entire contract between the Subscriber Group, Subscriber and us.

17.7 A Member's Copayments and Coinsurance are limited as stated on the Copayment and Coinsurance Schedule attached hereto.

17.8 The benefits of this Agreement are personal to the Member. The Member may not assign such benefits nor may the Member assign or otherwise transfer any claim, right of recovery or right to payment arising under this Agreement.

17.9 The rights of Members and our obligations shall be determined solely by this Agreement without regard to any other agreement or relationship between us and any Provider, Physician, Group Subscriber or other person. No Provider (except for services actually rendered by such Provider) or any director, officer, employee, agent or representative of ours is liable for the conduct of any Provider in furnishing health care services.

17.10 If your compensation is suspended or terminated directly or indirectly due to strike, lockout, or other labor dispute, you may continue your coverage by paying premiums directly to the Employer, for a period not exceeding six months. During that period of time, the policy may not be altered or changed. Thereafter, you will have the opportunity to purchase an individual policy.

The amount of your monthly payment for continued coverage will be equal to the full group monthly cost for the coverage, including any portion usually paid by the Employer. Such premium rate will be the applicable rate then in effect for coverage under the group plan on the date work ceases.

If you have Dependents covered on the date you cease to work, in order to continue your coverage you must also continue coverage for your Dependents by including the monthly cost for Dependents coverage with your monthly payment for continued coverage.

Your continued coverage under the special provision will cease on the earliest of:

a. the premium due date on or next after the date you begin full-time work as an employee of an employer other than the employer for whom you ceased to work because of the strike, lockout, or other labor dispute.

b. the premium due date on or next after the end of the 6-month period from the date you ceased to work because of the strike, lockout, or labor dispute; or

c. the premium due date on or next after the date the strike, lockout, or other labor dispute ends.

17.11 Subscriber Group and each Subscriber acknowledge that we, as most health care organizations, operate on a system which may involve one, more or all of the following: financial incentives, medical management and utilization review. Subscriber Group and all Subscribers acknowledge that, absent a declaration that any of the foregoing is contrary to public policy in the State of Washington, such system does not violate medical ethics nor constitute negligence, fraud, breach of trust or a tortious breach of the Physician/patient relationship.

17.12 We rely substantially upon licensing and regulatory authorities, continuing education requirements, Peer Review Committees, medical and Hospital staff decisions, Provider representations and insurability in the selection of Participating Providers. We are not responsible for the decisions of Providers.

17.13 It is understood that nothing in this Agreement shall entitle either party to this Agreement to recover attorneys' fees from the other party in the event of litigation between the parties, except as provided for by statute.

17.14 Each party shall advise the other as to matters that come to their attention with respect to potential substantial legal actions involving matters related to this Agreement, and shall promptly advise each other of legal actions commenced against each party that come to their attention. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Agreement by providing without additional fee all information relating to disputed claims and providing necessary testimony.

17.15 Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Agreement unless stated to be such in writing, signed by the parties and attached to this Agreement.

17.16 Members must submit claims to us for all services provided by Nonparticipating Providers within 90 days from the date the services were rendered or as soon as medically possible, but in no event later than one year from

the date services were rendered unless the Member is legally incapacitated throughout that year. Claims must include a statement describing the services rendered, date of services and charges therefore.

17.17 Notwithstanding any other provision of this Agreement, the provisions of this Agreement which, on or after the Group Effective Date, are in conflict with applicable state or federal laws or state or federal regulations, are hereby amended to conform to the minimum requirements of such laws or regulations.

17.18 This Agreement is issued and delivered in the State of Washington and is governed by the laws of the State of Washington.

17.19 When services are provided to a Member by a Participating Provider in accordance with the terms of this Agreement, the Member is responsible only for payment of the contractually stated Copayments, deductibles, and Coinsurance and for non-covered services. A Member shall not be responsible for amounts owed by us to a Participating Provider even if we are unable to pay.

17.20 No benefit, right or any interest of any beneficiary under this Agreement can be assigned or transferred and any such assignment or transfer shall be held invalid and void. Payment of any benefits hereunder shall, at our exclusive option, be made directly to the Physician, Hospital or institution providing their services, or to his or her representative, or directly to the beneficiary. Exception: We will make benefit payments for ambulance services directly to the ambulance company.

17.21 We may assign this Agreement to its successor in interest or an affiliate. We reserve the right to contract with other corporations, associations, partnerships, or individuals to provide services and supplies described in this Agreement.

17.22 Subscriber Group warrants that it presently has and will maintain throughout the term of this Agreement all coverage required of it by applicable workers' compensation or employer's liability laws or other laws of similar purpose.

17.23 If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions and the Agreement shall remain in force and effect, and in no way shall be affected, impaired, or invalidated.

17.24 The headings in this Agreement are provided solely for convenience of reference and are not a part of this Agreement or guides to interpretation hereof.

17.25 In the absence of fraud, all statements made by applicants, Subscriber Group or a Member shall be deemed representations and not warranties, and no statement made for the purpose of effecting coverage shall void the coverage or reduce benefits unless contained in a written instrument signed by Subscriber Group or a Member, a copy of which has been furnished to Subscriber Group or to the Member or the Member's beneficiary.

17.26 We do not consider the availability or eligibility for medical assistance under Medicaid in any state when considering eligibility for coverage or paying benefits for eligible Members under this plan.

17.27 Benefits payable under this Agreement are subject to the deductible shown in the Copayment and Coinsurance Schedule which must be satisfied each Calendar Year before benefits will be paid; however covered expenses used to satisfy the deductible during the last three months of a Calendar Year may also be used to satisfy the deductible for the following Calendar Year. The deductible carryover provision does not apply for a high deductible health plan.

Except for a high deductible health plan, the annual out-of-pocket maximum does not include the annual deductible. After you reach the out-of-pocket maximum in a Calendar Year, we will pay your covered services during the rest of the Calendar Year at 100% of our contracted rates for PPO services and at 100% of UCR for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed UCR.

When this Agreement immediately replaces a Subscriber Group's previous HNOR PPO Plan Agreement in the middle of a Calendar Year, we will credit amounts accumulated toward annual deductibles and out-of-pocket maximums.

17.28 Per RCW 48.43.545, we will adhere to the accepted standard of care for health care providers under chapter 7.70 RCW when arranging for the provision of medically necessary health care services to its enrollees. We shall be liable for any and all harm proximately caused by the failure of our employees, agents or ostensible agents who are acting on our behalf and over whom we have the right to exercise influence or control or over whom we have actually exercised influence or control to follow that standard of care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, an enrollee.

We are also liable for damages under (a) of this subsection for harm to an enrollee proximately caused by health care treatment decisions that result from a failure to follow the accepted standard of care made by our employees, agents or ostensible agents who are acting on our behalf and over whom we have the right to exercise influence or control or over whom we have actually exercised influence or control.

You may not maintain a cause of action under this section against us under this provision unless: a) you have suffered substantial harm. As used in this subsection, "substantial harm" means loss of life, loss or significant impairment of limb, bodily or cognitive function, significant disfigurement, or severe or chronic physical pain; and b) you or your representative has exercised the opportunity established in RCW 48.43.535 to seek independent review of the health care treatment decision. This does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or other relief available under law, if our requirements place your health in serious jeopardy.

Any action under this section shall be commenced within three years of the completion of the independent review process.

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888.802.7001
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Hearing and Speech Assistance
Monday - Friday 8:00 a.m. to 5:00 p.m.
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