

**THE BOEING COMPANY  
SELECT NETWORK® PLAN (UNION)  
SPEEA ACTIVE AND RETIRED EMPLOYEES**

- SPEEA, Engineers, Washington
  - SPEEA, Technical Unit, Nonexempt, Washington
  - Airplane Manufacturing Pilots Association
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**Effective January 1, 2010, the following changes are made to your Plan:**

The **Chemical Dependency** Benefit is revised to remove the lifetime maximum and dollar limitation. The sixth paragraph is removed and replaced with the following:

For the purpose of this Chemical Dependency Benefit, “medically necessary” is defined by the American Society of Addiction Medicine patient placement criteria. “Patient Placement Criteria” means the admission, continued service, and discharge criteria set forth in the most recent version of the *Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders* as published by the American Society of Addiction Medicine.

The **Prescription Drugs** Benefit is removed. The Prescription Drugs Benefit is no longer being administered by Regence BlueShield. Only drugs provided as part of inpatient and preventive care services are covered under this Plan. Any other benefits that direct the member to the Prescription Drugs Benefit in the brochure are revised to remove that reference. Retail and mail order prescription drug benefits are now being provided through Medco Health Solutions, Inc. Contact Medco at 1 (800) 841-2797 or [www.medco.com](http://www.medco.com).

The **Transplants** Benefit is revised to clarify that expenses for medically necessary services and supplies for the first 90-day period following the transplant will accrue to the transplant combined lifetime maximum. Any expenses incurred for medically necessary services and supplies related to a transplant after the initial 90-day period will accrue to the member’s lifetime maximum of the plan.

The **Limitations and Exclusions** provision in the **When Won’t Things Be Covered?** section is revised by the following:

The 11th bullet in the section is removed and replaced as follows:

- Drugs (except that inpatient benefits are provided for drugs supplied in a hospital or skilled nursing facility). Preventive injections or immunizations will be covered only as specifically provided in the Preventive Care Benefit in the “Benefits” section. FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment: 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. (For definitions of “off-label,” “standard reference compendia,” and “peer-reviewed medical literature,” please see the “Definitions” section.) No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.

A new Exclusion is added as follows:

- Services or supplies pursuant to a member seeking to end his or her life under the Washington Death with Dignity Act, as written under the Revised Code of Washington (RCW) 70.245.

The **Claim Review and Appeal** section is removed and replaced with the following:

## **BOEING MEMBER APPEAL POLICY**

Regence BlueShield offers an appeal policy to Boeing members or their designated representatives. This policy allows those who disagree with adverse benefit determinations made by Regence BlueShield regarding eligibility to participate in a Plan, application of utilization review, determination that a treatment is experimental or investigational, determination that a treatment is not medically necessary, or a Plan exclusion or limitation to obtain an objective review of such decisions. Copies of all documents, records and other information relevant to your claim for benefits, including the criteria for making this decision, are available in writing free of charge, upon request.

**First Appeal (Mandatory):** You or your designated representative may appeal a determination, verbally or in writing, within 180 days of receipt of written notification of the previous decision. Failure to request an appeal within the stated time period (absent the Plan's finding, in its sole judgment, of acceptable extenuating circumstances) will preclude your right to appeal and may jeopardize your right to contest the decision in any forum. You should include the reason for the appeal and may include any information or documents that you and/or your designated representative believe to support your position.

You or your designated representative will be notified of the Plan's decision within 15 calendar days of receipt of a first level appeal for pre-service claims and within 30 calendar days of receipt of a first level appeal for post-service claims.

**Second Appeal (Mandatory):** You or your designated representatives may initiate a second appeal of a determination verbally or in writing, within 180 days of receipt of written notification of the first level decision. Failure to request an appeal within the stated time period (absent the Plan's finding, in its sole judgment, of acceptable extenuating circumstances) will preclude your right to appeal and may jeopardize your right to contest the decision in any forum. You should include the reason for the appeal and may include any information or documents that you and/or your designated representative believe to support your position.

If the documentation does not clearly substantiate that the denial should be reversed, the appeal will be prepared for presentation to the Regence BlueShield Boeing Member Appeal Panel (the Panel). You will be notified by Regence BlueShield of the date, time, and location of the Panel's meeting and the right to participate and include others if you so desire.

You or your designated representative will be notified of the Panel's decision within 15 calendar days of receipt of a second level appeal for pre-service claims and within 30 calendar days of receipt of a second level appeal for post-service claims.

Following a second level of appeal, you may bring civil action under section 502(a) of the Employee Retirement Income Security Act of 1974. In addition, the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

There is a voluntary third level of appeal available through Regence BlueShield.

**Third Level Appeal (Voluntary External):** You or your designated representatives may request a final appeal of a determination, verbally or in writing, within 180 days of receipt of written notification of the previous decision. Failure to request an appeal within the stated time period (absent the Plan's finding, in its sole judgment, of acceptable extenuating circumstances) will preclude your right to appeal and may jeopardize your right to contest the decision in any forum. You should include the reason for the appeal and may include any information or documents that you and/or your designated representative believe to support your position.

Once a request for voluntary external appeal is made, the review decision must be made by an Independent Review Organization (IRO), unless the Plan sponsor and the Plan agree otherwise. The consultation of an independent medical professional with appropriate expertise will be limited to

determinations of whether a course or plan of treatment is medically necessary or experimental and/or investigational. The determination by an independent medical professional is a final and binding determination for coverage by Regence BlueShield. You or your designated representative will be notified of the Plan's final determination in writing.

**First Urgent Appeal (Mandatory):** You or your designated representatives may request an urgent appeal verbally or in writing within 180 days of receipt of the previous denial. Failure to request an appeal within the stated time period (absent the Plan's finding, in its sole judgment, of acceptable extenuating circumstances) will preclude your right to appeal and may jeopardize your right to contest the decision in any forum. You should include the reason for the appeal and may include any information or documents that you and/or your designated representative believe to support your position.

An urgent appeal is any pre-service or concurrent care claim for medical care or treatment for which the application of the time periods for making regular appeal determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the disputed care or treatment.

You or your designated representative will be notified of the Plan's decision within 72 hours of receipt of the appeal request. If the request does not warrant an urgent appeal, it will be handled through the standard appeal policy previously outlined.

Following a first urgent appeal, you may bring civil action under section 502(a) of the Employee Retirement Income Security Act of 1974. In addition, the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

There is a voluntary second level urgent appeal available through Regence BlueShield.

**Second Urgent Appeal (Voluntary External):** You or your designated representatives may request a final appeal of determination, verbally or in writing, within 180 days of receipt of written notification of the previous decision. Failure to request an appeal within the stated time period (absent the Plan's finding, in its sole judgment, of acceptable extenuating circumstances) will preclude your right to appeal and may jeopardize your right to contest the decision in any forum. You should include the reason for the appeal and may include any information or documents that you and/or your designated representative believe to support your position.

Once a request for voluntary external appeal is made, the review decision must be made by an Independent Review Organization (IRO), unless the Plan sponsor and the Plan agree otherwise. The consultation of an independent medical professional with appropriate expertise will be limited to determinations of whether a course or plan of treatment is medically necessary or experimental and/or investigational. The determination by an independent medical professional is a final and binding determination for coverage by Regence BlueShield. You or your designated representative will be notified of the Plan's final determination in writing.

<b>Submit Appeals by Mail:</b>	Regence BlueShield Boeing Appeals and Correspondence P. O. Box 91015 Mail Stop BU248 Seattle, WA 98111-9115
<b>Fax:</b>	1 (877) 663-7526
<b>Email:</b>	boeing@regence.com

**Allowed Amount:** The allowed amount shall mean one of the following:

- **Selections Network Plan (POS), Preferred Plan (PPO), or Participating Providers Inside The Service Area, Who Have Agreements With The Company:** For services or supplies covered under this plan, the amount these providers have agreed to accept as payment in full is pursuant

to the applicable agreement between the Company and the provider. These providers agree to seek payment from the Company when they furnish covered services to you. You will be responsible only for any applicable deductible, copays, coinsurance, and charges in excess of the stated benefit maximums, if any, and for charges for services and supplies not covered under this plan.

- ***Preferred Plan or Participating Providers Outside The Service Area Who Have Agreements With Other Blue Cross and/or Blue Shield Licensees:*** The allowed amount is determined as stated in the Outside the Service Area provision of the “How Do I File A Claim?” section.
- ***Recognized Providers Who Do Not Have Agreements With The Company Or Another Blue Cross and/or Blue Shield Licensee:***

The allowed amount is the least of:

- The provider’s actual charge for the service or supply;
- The provider’s normal charge for a similar service or supply; or
- A predetermined percentile of charges made by providers of a comparable service or supply in the geographic area where it is received.

To determine if a charge exceeds the allowed amount for medical services or supplies in situations involving unusual or complicated services or supplies, the nature and severity of the injury or sickness may be considered.

The Company uses a database of provider charges, chosen by the Plan sponsor, to determine the allowed amount in an area. Information about the database and percentile used to determine the usual and customary charge can be obtained by contacting the Company.

If you use a recognized provider, you pay any charges above the allowed amount.

The definition of **Medically Necessary** in the “**Definitions**” section is revised by adding the following sentence to the end of the last paragraph:

(If “Medically Necessary” is specifically defined in any benefit under the “Benefits” section of this brochure, such definition shall be applicable for purposes of that benefit instead of this definition.)

**Please keep this insert with your brochure for an up-to-date record of changes to your Plan.**

**We encourage you to use our secure, members-only Web site, [www.myRegence.com](http://www.myRegence.com), powered by the Regence Engine®. Designed to advise, navigate and reward, this resource provides claims history, community message boards, expert health and wellness advice, and other tools to enhance your health and wellness. You can also use myRegence.com’s Live Help feature to instantly chat with our Customer Service team, Monday through Friday, 7 a.m. to 5 p.m. Pacific time.**

# Select Network<sup>SM</sup> Plan (Union)

## SPEEA Guide to Benefits



Regence BlueShield  
is an Independent Licensee of the Blue Cross and Blue Shield Association



Regence

**Select Network Plan**

Effective July 1, 2009

# **WELCOME**

## **HOW CAN WE HELP YOU?**

At Regence BlueShield, we believe in providing the highest quality customer service. This means that we offer top-notch benefit plans, strong provider networks and hassle-free health care, with customer service staff who can answer your questions quickly and accurately. Providing coverage since 1917, we stand by our original goal: to be the first choice in health plans in the communities we serve.

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# WELCOME TO A DIFFERENT KIND OF HEALTH PLAN.

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Welcome to the Select Network<sup>SM</sup> Plan, an Exclusive Provider Organization (EPO). As you'll soon discover, this health plan isn't like health plans used to be.

For starters, it can help reduce the amount of out-of-pocket money you have to spend on health care. All this is made possible by a partnership that includes your employer, your health care provider, Regence BlueShield, and you. Working together, we can reduce unnecessary medical expenses, so you can have care that's both appropriate and affordable.

As a member of the Select Network Plan, you'll receive this care from a carefully selected network of doctors, hospitals, and other health care providers.

This Guide to Benefits explains how that works, answers questions about your coverage, defines the special terms used (please see the "Definitions" section of this Guide to Benefits), and instructs you on how to use the plan to best meet your needs. Please read it carefully to become familiar with all of the advantages of your Select Network Plan.

*This supplement describes the health care plan that is available to you and your family if you are an eligible union-represented employee or retiree of The Boeing Company. The plan described in this supplement is provided in accordance with the unions listed below:*

## **Union Salaried Active and Retirees**

SPEEA, Engineers, Washington  
SPEEA, Technical Unit, Nonexempt, Washington  
SPEEA, Engineering Unit, Engineers, Florida  
Airplane Manufacturing Pilots Association

This description of the Regence BlueShield plan and accompanying mental health and chemical dependency, prescription drug, and vision care programs, is a supplement to the current edition of *The Boeing Company Health and Welfare Plans Summary Plan Descriptions* for the union-represented employees and retirees of The Boeing Company.

For detailed information concerning employee and dependent eligibility, enrollment, contributions, coverage terminations, leave of absence provisions, eligibility reviews and appeals, Qualified Medical Child Support Orders (QMCSO), ERISA Special Disclosures and other general plan information, refer to *The Boeing Company Health and Welfare Plans Summary Plan Descriptions*, or contact the plan administrator.

The health plan benefit description is incorporated as part of the Boeing Summary Plan Descriptions. The summary plan description for this plan is The Boeing Company Health and Welfare Plans booklet for the eligible population, any applicable provider directory and this coverage-specific Guide to Benefits as issued by Regence BlueShield.

*Note: In this Guide to Benefits, Regence BlueShield is referred to as the "Company."*

*Regence BlueShield has contracted with The Boeing Company to provide administrative services, including claims processing, and does not assume any financial risk or obligation with respect to claims.*

## **WHAT DO I NEED TO DO *BEFORE* I GET CARE?**

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Your Select Network Plan includes a health management program designed to encourage you to be aware of—and involved in—decisions about the most appropriate level of medical care.

### **VOLUNTARY SECOND SURGICAL OPINION**

If you choose to have a voluntary second surgical opinion before having surgery, the physician's services and any related x-ray and laboratory services for the second opinion will be provided in full, subject to the provisions of this plan.

Your Selections network physician or the Company can furnish the names of physicians from whom the second opinion may be obtained. The second opinion must be obtained from a physician within your Network Plan and who is not the physician who will perform the surgery. The Regence Select Network Plan uses the Selections network of providers.

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

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

## **WHAT DO I DO WHEN I NEED CARE?**

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Your Select Network Plan is designed to be as simple to use as possible. When you need medical care, just follow these steps. That way, you'll be assured of receiving the Select Network Plan level of benefits. Your Select Network Plan benefits do not require you to choose a Personal Care Provider (PCP). If you choose to see a specialist, you do not need to obtain a referral. If you self-refer to a Network provider for your care, the Regence Select Network Plan uses the Selections network of providers.

### **CARE WITHIN THE SELECT NETWORK PLAN SERVICE AREA**

To obtain care, be sure to present your Select Network Plan member identification card to your provider before receiving care. If you lose your member identification card, call 1-800-422-7713 or visit our Web site at [www.myRegence.com](http://www.myRegence.com) to request a replacement member identification card. This service will be provided at no cost to you. Within the service area, no benefits will be provided unless you are under the care of a Selections network provider. Selections network providers are located in the following counties of Washington state: Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima.

The benefits of this plan will be provided for any service performed by a registered nurse acting within the scope of the license if this plan would provide benefits for the services when performed by a physician. You will be reimbursed up to the percentage of the allowed amount as specified for other physician services.

### **EMERGENCY CARE**

If you have a medical emergency, go to the nearest appropriate facility. In an emergency, treatment by a provider that is not normally covered under this plan will be recognized for 24 hours, or as long as it reasonably takes to come under the care of a Selections network provider. Benefits will be based on the recognized provider's actual charge for the service where those charges are reasonable and are not increased on the basis of the coverage of this plan. *If you are admitted to a hospital outside the service area, you must call us within 24 hours or the next business day to continue to receive full plan benefits.*

Please refer to the “Definitions” section to see how a medical emergency is defined for this plan.

## **HEALTH CARE PLAN RESPONSIBILITY**

All health care services are provided by facilities and professionals who are neither employees nor agents of the Company. The fact that a provider is listed in the Company’s provider directory does not mean the provider is the Company’s employee or agent. Providers are responsible for the quality of care they render.

## **CARE OUTSIDE THE SERVICE AREA**

Outside the Select Network Plan service area, benefits will be provided for care received from a Preferred Plan, participating, or recognized provider (see the “Definitions” section) for emergencies only based on the allowed amount at the level specified in the Payment Schedule.

If you live inside the service area and are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours (or the next business day) to receive full plan benefits.

You must also agree to comply with the Company’s guidelines, which may require you to move under the care of a Selections network provider in the service area as soon as the Company feels it is medically feasible. If you meet all requirements, inpatient benefits will be provided at the Select Network Plan level.

For dependent children living outside the Select Network Plan service area, please see the Benefit Payment Schedule.

Remember to present your member identification card when consulting a provider or receiving treatment at a hospital. By using your member identification card, participating providers can submit your claims to the local Blue Cross and/or Blue Shield plan.

*See the “How Do I File A Claim?” section of this Guide to Benefits for information on submitting claims.*

## WHAT DO I HAVE TO PAY FOR?

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

### COPAYS

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

- \$10 copay for each outpatient professional service, including vision and hearing exams, (except laboratory and x-ray; hearing tests; preventive care services; outpatient surgery; radiation and chemotherapy; hospice; home health; home phototherapy; tobacco cessation; and benefits outside the service area) performed in the office, home, hospital outpatient department or other facility. Copays apply to all outpatient professional services as noted in the “Benefits” section.
- \$50 copay for each visit to a hospital emergency room for illness, injury or surgery. This amount will be waived if you are directly admitted to the hospital as an inpatient, if you are treated in the emergency room for 12 or more hours, if directly transferred to another ER, or in the event of your death.

### DEDUCTIBLE

The deductible is the cost of **covered** medical expenses outside the Select Network Plan. The deductible amount applies only to eligible dependent children living outside the Select Network Plan service area and is \$400 per dependent child, per benefit year.

Any copays required by this plan, charges for services and supplies not covered by this plan, any expenses for services not subject to the deductible, and expenses for covered services or supplies in excess of the allowed amount, except as specified in the Emergency Care provision in the “What Do I Do When I Need Care?” section, will not apply to your deductible.

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

**Family Accident Deductible:** If two or more covered family members are injured in the same accident, they need to satisfy only

one deductible for any benefits provided in that and the next benefit year as a result of the accident.

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

**If Hospitalization Continues From One Benefit Year Into the Next:** A second deductible will not be required for any treatment prior to your discharge from the hospital.

## **MAXIMUM BENEFIT**

The benefits of this plan are limited to a \$2,000,000 lifetime maximum per covered person. This maximum applies to all combined benefits provided under this plan. In addition, at the beginning of each benefit year the amount charged against your lifetime maximum will be reduced by \$20,000.

## PAYMENT SCHEDULE

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

### Benefit Payment Level for Services Provided by Selections

**Network Providers Inside the Service Area:** You may contact the Company for up-to-date information on Selections network providers.

<u>Benefit</u>	<u>Select Network Plan Benefits</u>
Preventive Care (see the Preventive Care Benefit for details on out-of-area benefits for dependent children)	100%
Professional Services (as described in the “Benefits” section including diagnostic x-ray and laboratory services)	100% (unless specified otherwise)
Hospital Services* (inpatient and outpatient benefits including diagnostic x-ray and laboratory services) \$50 copay per emergency room visit (waived if admitted, if treated for 12 or more hours, if directly transferred to another ER, or in the event of death)	100%
Acupuncture	100%
Ambulatory Surgical Center	100%
Chemical Dependency (care must be coordinated through ValueOptions)	100%
Diabetes Care Training	100%
Growth Hormone	100%

*\* Services and supplies required to treat a medical emergency inside the service area will be provided at the Select Network Plan level of benefits as specified in the Emergency Care provision in the “What Do I Do When I Need Care?” section.*

<u>Benefit</u>	<u>Select Network Plan Benefits</u>
Hearing Aids	100%
Home Health	100%
Home Medical Equipment	80%
Home Phototherapy	100%
Hospice	100%
Hospitalization for Dental Services	100%
Infusion Therapy	100%
Mammography	100%
Maternity	100%
Mental Health (care must be coordinated through ValueOptions)	100%
Neurodevelopmental Therapy	100%
Newborn Care	100%
Phenylketonuria Formulas	100%
Preadmission Testing for Surgery	100%
Prenatal Testing	100%
Prostate Cancer Screening	100%
Prostheses and Orthotics	80%
Rehabilitative Services	100%
Routine Eye and Hearing Examinations (see the Routine Eye and Hearing Examinations Benefit for details on out-of-area benefits for dependent children)	100%
Skilled Nursing Facility	100%
Special Equipment and Supplies	80%
Spinal and Extremity Manipulations	100%
Sterilization Procedures	100%
Temporomandibular Joint Disorders	100%
Tobacco Cessation	80%
Transplants	100%

**Benefit Payment Level for Services Provided by Recognized Providers Inside the Service Area:**

<u>Benefit</u>	<u>Select Network Plan Benefits</u>
Ambulance Services	100%
Blood Bank	80%
Repair of Teeth	80%
Temporomandibular Joint Disorders (services of dentists)	100%

**Benefit Payment Level for Services Provided Outside the Service**

**Area:** If you receive care outside the service area, you will receive the Select Network Plan benefits only for medical emergencies. If you live inside the service area and become admitted as an inpatient while traveling outside the service area, you will receive the Select Network Plan benefits if you follow special notification procedures and other requirements. (See the "What Do I Do When I Need Care?" section.)

Benefits for care received outside the service area by eligible dependent children living outside the service area, including preventive care, will be provided at 80% of the allowed amount after satisfaction of the \$400 benefit year deductible, subject to the benefit provisions and limitations described in this Guide to Benefits. No other benefits for care received outside the service area are available, except for medical emergencies.

# BENEFITS

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**All covered benefits explained on the following pages are subject to a copay amount, except as noted below.**

All covered benefits are subject to the **limitations, exclusions, and provisions** of this plan, and services and supplies must be medically necessary. Limited benefits are not cumulative and unused portions of them cannot be carried over from one benefit year to another benefit year, except as otherwise specified. You must receive services from Selections network providers (Select Network Plan members utilize the Selections network of providers; see the “Definitions” section), as outlined in the Payment Schedule, to be eligible for the benefits of this plan. The services of recognized providers (see the “Definitions” section) inside the service area are only available for benefits as outlined in the Payment Schedule. Benefits for medical emergencies will be provided as specified in the Emergency Care provision of the “What Do I Do When I Need Care?” section. Benefits are identical for subscribers and dependents, except where otherwise specified.

**Preventive Care:** The services of a Selections network physician will be provided when performed on an outpatient basis at the same level as benefits for illness conditions. Copays do not apply to Preventive Care Benefits. The following services will be provided:

- Routine well baby care from birth.
- Routine pediatric, routine gynecological and adult physical examinations.
- Pediatric and adult immunizations.
- Office calls and related laboratory and x-ray services for routine cancer screening including preventive surgeries. (Routine mammography and routine prostate cancer screening services are covered separately under the “Benefits” section and are not part of the Preventive Care Benefit.)
- Routine colorectal cancer screening services, including but not limited to, colonoscopies, sigmoidoscopies, fecal occult tests and barium enemas.

No other Preventive Care Benefits are available outside the Select Network Plan service area (except as provided below). Preventive Care Benefits for eligible dependent children living outside the service area, will also be provided at 80% of the allowed amount after satisfaction of the deductible.

**Routine Eye and Hearing Examinations:** The services of a Selections network physician, a Selections network optometrist, or

an audiologist will be provided for routine eye and hearing examinations. The following services will be provided:

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

Benefits for glasses, contact lenses, or hearing aids will be provided as specifically stated in the applicable Vision Care Benefit or the Hearing Aid Benefit. Routine eye and hearing examinations for eligible dependent children living outside the service area, will also be provided at 80% of the allowed amount after satisfaction of the deductible. No other benefits for routine eye and hearing examinations are available outside the Select Network Plan service area.

**Professional Services:** The services of a provider who is not a facility that provides inpatient services will be provided for injury and illness, including x-ray, laboratory, surgery, second opinions, and injectable drugs for covered conditions in the office, home, hospital or skilled nursing facility. The services of a provider who is a physician, a physician's assistant, a midwife, or an advanced registered nurse practitioner specializing in women's health and midwifery will be provided to a female for covered women's health care services. Covered women's health care services include gynecological care, maternity care, mammograms and general examinations as medically appropriate and medically appropriate follow-up visits. For maternity care, see the Maternity Benefit of this plan. Copays apply to all services except laboratory and x-ray; hearing tests; preventive care services; outpatient surgery; radiation and chemotherapy; hospice; home health; home phototherapy; tobacco cessation; and benefits outside the service area.

**Hospital Services:** The inpatient and outpatient services of a hospital will be provided for injury and illness (including services of staff providers billed by the hospital). Room and board is limited to the hospital's average semiprivate room rate except where a private room is determined to be medically necessary. You will be responsible to pay the emergency room copay for each hospital emergency room visit (waived if directly admitted to the hospital as an inpatient, if you are treated in the emergency room for 12 or more hours, if directly transferred to another ER, or in the event of your death). All other services of the hospital outpatient department, except outpatient surgery, radiation and chemotherapy, are subject to the outpatient professional copay.

**Acupuncture:** The Professional Services Benefit of this plan will be provided to a 12-visit limit per benefit year for acupuncture services, except that acupuncture for chemical dependency treatment will be

provided separately under the Chemical Dependency Benefit of this plan.

**Ambulance Services:** The services of an ambulance company (ground or air ambulance service) will be provided to the nearest hospital equipped to render the necessary treatment, if other transportation would endanger your health and the purpose of the transportation is not for personal or convenience reasons.

**Ambulatory Surgical Center:** The services and supplies of an ambulatory surgical center will be provided for injury or illness.

**Blood Bank:** The services and supplies of a blood bank will be provided.

**Chemical Dependency:** To receive the Select Network Plan benefits for chemical dependency, you must contact ValueOptions, the independent managed behavioral health organization contracted to manage the Chemical Dependency Benefits of this plan, at the telephone number listed in the Customer Service Directory at the end of this Guide to Benefits. ValueOptions will then work with you to evaluate the level of care you need and locate an appropriate Network provider for treatment.

The services and supplies of a chemical dependency treatment program will be provided for medically necessary inpatient and outpatient treatment for chemical dependency, including supportive services. If you use the Network provider referred by ValueOptions, benefits will be provided at 100% of the allowed amount. If care is not coordinated through ValueOptions, services will not be covered.

Benefits will be provided to a lifetime maximum of two courses of treatment not to exceed a maximum of \$7,500 per course. Medically necessary detoxification will be covered as a medical emergency and expenses incurred will not accrue to the lifetime maximum if the member is not enrolled in another chemical dependency treatment program. Copays apply to outpatient treatment.

Acupuncture services related to chemical dependency treatment will be provided under this Chemical Dependency Benefit and will accrue to the overall Chemical Dependency Benefit maximum. Acupuncture services provided under this Chemical Dependency Benefit do not accrue to the 12-visit limit per benefit year, as specified in the Acupuncture Benefit.

Prescription drugs related to chemical dependency treatment and prescribed and dispensed through a chemical dependency treatment facility will be provided under the benefits of this Chemical Dependency Benefit and will accrue to the overall Chemical Dependency Benefit maximum.

When the member is under court order to undergo a chemical dependency assessment or in other situations pending legal action related to chemical dependency, the Company reserves the right to require the member, at the member's expense, to provide a chemical dependency treatment plan and an initial chemical dependency assessment performed by a chemical dependency counselor employed by a chemical dependency treatment program, at least 10 days before treatment begins.

For the purpose of this Chemical Dependency Benefit, "medically necessary" means as indicated in the *Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II* as published in 1996 by the American Society of Addiction Medicine.

No benefits will be provided for information and referral services; information schools; Alcoholics Anonymous and similar chemical dependency programs; long-term care or custodial care; tobacco cessation programs, except as provided in the Tobacco Cessation Benefit of this plan; and emergency service patrol. No other Chemical Dependency Benefits will be provided under this plan, except as described above for detoxification.

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

**Diabetes Supplies and Equipment:** The benefits of this plan will be provided for supplies and equipment for the treatment of diabetes. For Professional Services, Diabetes Care Training, Home Medical Equipment, Prostheses and Orthotics, and Prescription Drugs Benefits, see those benefits of this plan.

**Growth Hormone:** Services and supplies will be provided for growth hormone when performed and billed by an infusion therapy provider for the following:

- For children with growth hormone deficiency, Turner's syndrome, chronic renal insufficiency, Prader-Willi syndrome, neonatal hypoglycemia associated with growth hormone deficiency, or for other conditions determined by the Company to be a covered benefit since this plan was issued.
- For adults with growth hormone deficiency as a result of hypothalamic or pituitary disease due to destructive lesion of the pituitary, or peri-pituitary area, as a result of treatment or surgery, or for other conditions determined by the Company to be a covered benefit since this plan was issued.

Growth hormone treatment of these listed conditions is covered when authorized by the Company in advance. Benefits for growth hormones are provided to a maximum of \$25,000 per benefit year. No other benefits for growth hormone will be provided under this plan.

**Hearing Aids:** When required due to permanent hearing loss, benefits will be provided for hearing aids to a maximum of \$600 per ear every three benefit years, including the cost of the hearing aids and installation when recommended in writing by a physician or a certified audiologist. No benefits will be provided for routine maintenance or alteration of a hearing aid. Benefits provided for repair of hearing aid equipment are included in the \$600 limit. An item ordered prior to your effective date of coverage is not covered, even if delivered after the effective date of coverage. An item ordered while you were covered and delivered within 45 days after termination of coverage will be provided.

**Home Health:**

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

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

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

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

- Intermittent skilled nursing services.
- Skilled physical, occupational, and speech therapy services.
- Respiratory therapy services.
- Skilled medical social services.
- Home health aide services. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Medical supplies dispensed by the home health agency that would have been provided on an inpatient basis.
- Nutritional guidance.

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

**Limitations and Exclusions:** Any expenses for home care which qualify both under this benefit and under any other benefit of this plan may be covered only under the benefit the Company determines to be the most appropriate.

**No benefits will be provided for the following:**

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

**Home Medical Equipment:** Home medical equipment rented or purchased (if approved by the Company) from a home medical equipment company will be provided for therapeutic use. Such equipment includes crutches, wheelchairs, kidney dialysis equipment, standard hospital beds, equipment for the administration of oxygen, and medically necessary diabetic equipment, such as blood glucose monitors, insulin infusion devices, and insulin pumps including accessories to the pumps. To be covered, equipment must meet certain criteria established by the Company. Equipment ordered before your effective date of coverage will not be provided. Equipment ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of home medical equipment due to normal use or growth of a child will be provided.

"Home medical equipment" means the equipment can withstand repeated use; its only function is for treatment of the medical condition, or it contributes to the improvement of function related to the condition and is generally not useful in the absence of the condition; and it is appropriate for home use. Equipment whose primary purpose is preventing illness or injury, items primarily designed to assist a person caring for the patient, and items generally useful in the absence of the condition will not be covered.

No benefits will be provided for items such as, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, corrective shoes, heating pads, enuresis (bed wetting) training equipment, exercise equipment, weights, whirlpool baths, keyboard communication devices, adjustable beds, orthopedic chairs, home birthing tubs, personal hygiene items, or ramps or remodeling to accommodate the use of home medical equipment. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. The Company may elect to provide benefits for a less costly alternative item.

**Home Phototherapy:** Services and supplies furnished by a home phototherapy provider will be provided for newborn hyperbilirubinemia (newborn jaundice).

**Hospice:**

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

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

- Nursing services.
- Physical, speech, occupational, and respiratory therapy services.
- Medical social services.
- Home health aide services. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis.
- Nutritional guidance.
- Respite care for a minimum of two or more hours per day (continuous care of the patient to provide temporary relief to family members or friends from the duties of caring for the patient).

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

**Covered Inpatient Services:** When you are confined as an inpatient in a hospice that is not a hospital or skilled nursing facility, the same benefits that are available in your home will be available to you as an inpatient. Room and board is limited to the hospice's average

semiprivate room rate, except where a private room is determined to be medically necessary. The services must be provided by employees of and billed by the hospice. This inpatient Hospice Benefit will be limited to 14 days during the six-month benefit period. For services in a hospital or skilled nursing facility, see the Hospital Services and Skilled Nursing Facility Benefits of this plan.

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

- Respite care of two or more hours per day in which no skilled care is required will be limited to a combined total of 120 hours per three-month period.
- Any expenses for hospice care that qualify both under this benefit and under any other benefit of this plan will be covered only under the benefit the Company determines to be the most appropriate.

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

**No benefits will be provided for the following:**

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

**Hospitalization for Dental Services:** Services and supplies of this plan for hospitalization will be provided for dental services (including anesthesia), if hospitalization is medically necessary to safeguard your health. Benefits will cover the services of a physician, an ambulatory surgical center, and the inpatient and outpatient services of a hospital. Benefits are not available for the charges of a dentist; hospitalization for myofascial pain syndrome and any related

appliances; or hospitalization for malocclusions or other abnormalities of the jaw, except when specified otherwise.

**Infusion Therapy:** Services and supplies for infusion therapy will be provided. Drugs and supplies used in conjunction with infusion therapy will be provided only under this Infusion Therapy Benefit.

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

**Maternity:** Medical services including prenatal and postnatal treatment of pregnancy (including false labor), normal or cesarean delivery, and voluntary termination of pregnancy shall be treated the same as any other illness or injury and are provided for a female member for services incurred while she is covered under this plan. Covered inpatient and postpartum services will be provided when ordered by the attending provider in consultation with the female member for at least 48 hours following a normal delivery or for 96 hours following a cesarean section, unless a shorter stay is authorized by the attending provider. Treatment of complications arising from pregnancy will be provided the same as any other illness or injury. Complications of pregnancy include, but are not limited to, diabetes if onset is after conception, fetal distress, and toxemia. Charges for false labor or charges in connection with a normal pregnancy, cesarean section, or voluntary termination of pregnancy, are treated as Maternity Benefits except any complications that may arise.

**Mental Health:** Benefits for mental health under this plan are limited to the following:

To receive the network benefits for mental health, you must contact ValueOptions, the independent managed behavioral health organization contracted to manage the Mental Health Benefit of this plan, at the telephone number listed in the Customer Service Directory at the end of this Guide to Benefits. ValueOptions will then work with you to evaluate the level of care you need and assist you in finding an appropriate ValueOptions network provider for treatment. In order to appropriately administer your benefits, the organization will need to evaluate diagnostic details, treatment health codes, treatment plans, and progress notes from the mental health provider.

If you use the network provider referred by ValueOptions, benefits will be provided at 100% of the allowed amount. If care is not coordinated through ValueOptions, services will not be covered.

After ValueOptions has determined the level of care you need and referred you to a network provider, the following benefits for mental health treatment will be provided during a benefit year.

Inpatient mental health care, partial hospitalization, and residential treatment must be provided by an accredited general psychiatric hospital, state mental hospital as defined in state law, or a licensed community mental health agency that has an accredited inpatient facility.

Outpatient mental health treatment must be provided by a physician (M.D. or D.O.), psychologist (PhD or PsyD), advanced registered nurse practitioner (ARNP), licensed independent clinical social worker (LICSW), licensed mental health counselor (LMHC), licensed marriage and family therapist (LMFT) (however, marriage counseling will not be covered and family counseling will only be covered when the identified member is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment), or a licensed community mental health agency. Copays apply to outpatient treatment.

Services which may be covered under this benefit include, but are not limited to, diagnostic testing and treatment for mental disorders with a congenital or physical basis, diagnostic testing for learning disabilities, mental disorders related to a self-inflicted injury or attempted suicide, and mental disorders related to an eating disorder. Some benefit restrictions may apply. See the "When Won't Things Be Covered?" section for specific services excluded under this plan.

**Neurodevelopmental Therapy:** The benefits described below will be provided for the treatment of neurodevelopmental delay when treatment is performed for the purpose of restoring and improving function for children age six and under. In addition, this benefit includes maintenance services where significant deterioration of the member's condition would result without the service. Benefits will be provided as follows:

- Physical, speech and occupational therapy will be provided in the office, home or hospital outpatient department.
- All treatment must be prescribed by a Selections network provider, except for dependent children living outside the service area.
- Regular inpatient Hospital Services and Skilled Nursing Facility Benefits will be provided for an inpatient neurodevelopmental therapy admission when care cannot safely be provided on an outpatient basis. Hospital services must be provided in a hospital approved by the Company for rehabilitative care.

- “Neurodevelopmental delay” means a delay in normal development which is not related to a documented illness or injury.
- Benefits will be limited to \$1,500 per benefit year for all neurodevelopmental therapy services combined. Copays apply to outpatient treatment. You will not be eligible for both the Rehabilitative Services Benefit and this benefit for the same services for the same condition.
- No benefits will be provided for custodial care; maintenance (except as specified above); nonmedical self-help; recreational, educational, or vocational therapy; mental disorder care; chemical dependency rehabilitative treatment; gym or swim therapy.

**Newborn Care: Coverage is provided for Newborn children of subscribers, spouses, and covered domestic partners only.** The regular benefits of this plan will be provided for the newborn child enrolled in the plan from the date of birth. Benefits will be subject to all provisions, limitations, and exclusions of this plan.

The following services and supplies are covered for newborns when the mother is eligible for maternity benefits:

Hospital services and supplies and physician services during the first 48 hours following a normal delivery or 96 hours following a cesarean section, unless a shorter stay is authorized by the attending health care provider in consultation with the mother. Coverage beyond these timeframes will be provided only to enrolled newborns.

**Preadmission Testing for Surgery:** The services of a physician and hospital will be provided for outpatient preadmission testing for surgery at the hospital where you will be confined, if you are admitted within 48 hours after testing begins.

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

**Prescription Drugs:** Prescription drugs (including oral contraceptives) and other covered items will be provided in full as described below after you have paid the specified copay amount. Prescription drugs and other covered items must be furnished by a participating pharmacy or a participating mail order supplier. A list of these participating pharmacies, along with a list of participating out-of-state pharmacies is available on our Web site at [www.regenceRx.com](http://www.regenceRx.com). **Benefits will be subject to any applicable limitations and exclusions, except that Prescription Drugs**

**Benefits will not be subject to the coordination of benefits provisions or to any deductible provision described in this plan.**

***Getting Your Prescription Filled:***

- Present your member identification card at a participating pharmacy.
- Pay your applicable copay amount for each prescription dispensed (up to a 34-day supply). Your applicable copay amount will not vary as a result of the day supply prescribed.
- Prescription drugs furnished by a participating pharmacy will be limited to a 34-day supply, except as otherwise specified.

***Using Our Mail Order Service:***

- Pay your applicable copay amount for each prescription dispensed (up to a 90-day supply). Your applicable copay amount will not vary as a result of the day supply prescribed.
- Send an order form and the prescription along with your copay amount to the address listed on the mail order service form.
- Prescription drugs furnished by mail order will be limited to a 90-day supply per purchase, except that certain drugs, including but not limited to antidepressants, narcotics, and other select medications may be limited to a lesser supply as indicated on your prescription or as required by the Company.
- Drugs requiring continuous refrigeration may not be available through mail order service.

***Covered Items:*** Prescription drugs will be covered when medically necessary for the treatment of an illness, injury, or disability covered under this plan, subject to all provisions described below. Other items covered under this benefit and requiring a prescription include:

- Legend vitamins for prenatal care.
- Tobacco cessation prescription drugs and medications, limited to a 90-day lifetime maximum supply.
- Diabetic supplies, including insulin and insulin syringes.
- Oral contraceptive drugs will be provided for a single copay per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one copay per monthly cycle.

***Formulary:*** A formulary is a list of selected generic and brand-name preferred drugs, which is established, reviewed, and updated routinely by the Company. You will be required to pay more if the drug does not appear in the formulary. All drugs are reviewed and selected for inclusion in the Company's formulary by an outside committee of providers, including physicians and pharmacists.

Drugs are selected based on published scientific evidence and support proper use and cost-effective medication decisions. If clinical data show several drugs are equally effective, the committee usually chooses the most cost-effective ones. For convenience, the list is available on our Web site at [www.regenceRx.com](http://www.regenceRx.com).

**Copays:** You will be responsible for paying the appropriate copay level as specified below for each covered prescription or refill.

**Tier 1 – Generic Formulary Drugs** – means drugs included in the formulary that are equivalent to the brand-name version, are marketed and sold by more than one source, and are listed in widely accepted references as a generic drug based on manufacturer and price. Equivalent means the U.S. Food and Drug Administration (FDA) ensures that the generic must: a) have the same active ingredients found in the brand-name version; b) meet FDA specifications for quality, purity, and potency; and c) have the same medical effect as the brand-name version.

Participating Pharmacies .....\$5.00  
 Participating Mail Order Service.....\$10.00

**Tier 2 – Brand-Name Formulary Drugs** – means drugs included in the formulary that are under patent and are generally marketed and sold by only one source.

Participating Pharmacies .....\$15.00  
 Participating Mail Order Service.....\$30.00

**Tier 3 – Non-Formulary Drugs** – means drugs that do not appear in the formulary list established by the Company.

Participating Pharmacies .....\$30.00  
 Participating Mail Order Service.....\$60.00

*However, if the allowed amount is less than the appropriate copay you will pay only the allowed amount. If your provider prescribes or you elect to purchase a brand-name drug for which a less expensive generic equivalent is available, you will be responsible for paying the difference in price between the brand-name drug and the generic drug in addition to the generic copay amount.*

**Limitations:** Benefits for prescription drugs and other covered items will be limited as follows:

- Prescription drugs must be prescribed by a provider covered under the plan who is acting within the scope of his or her license.
- Certain prescription drugs require preauthorization from the Company before they are covered. Participating pharmacies have

been provided with a list of those drugs along with preauthorization requirements.

- Prescription drugs related to transplants are covered under this Prescription Drugs Benefit, however, claims for such drugs will be applied to and are subject to the Transplants Benefit maximum of this plan.
- Certain drugs may be limited to a lesser supply as indicated on your prescription or as determined by the Company. Participating pharmacies have been provided with a list of those drugs.
- Any drug purchased outside the United States must have an equivalent to a prescription drug approved by the FDA to be a covered benefit under this plan, and must be either:
  - Associated with a medical emergency while you are traveling. When submitting a claim for reimbursement, you will be responsible for notifying the Company that the prescription was required for a medical emergency; or
  - When you are residing outside the United States. When submitting a claim for reimbursement, you will be responsible for notifying the Company that your residence is outside the United States. The medication needs to be purchased in the country in which you are residing, except for a medical emergency.
- The Company may require you to obtain all prescriptions from a single participating pharmacy when reasonably necessary.

**Exclusions:** The following items are not covered under this Prescription Drugs Benefit due to plan exclusions or, as noted, covered under another benefit of this plan:

- Any items limited or excluded by this plan, except where specifically provided.
- Appetite suppressants and drugs for weight loss.
- Drugs or medications used for cosmetic purposes.
- Drugs dispensed by a non-participating pharmacy, except when specifically provided for cases of emergency, or outside the service area.
- Inside the United States, any prescription drug that has not been approved by the FDA, including compounded products with active ingredient(s) that have not been approved by the FDA.
- Any drugs or items obtained from a participating pharmacy when you fail to present the member identification card.
- Over-the-counter medications (OTC) and any prescription medication with the same active ingredients and in the same strength as an over-the-counter product.
- Replacement prescriptions resulting from loss, theft, or breakage.
- Growth hormone, except as specified in the Growth Hormone Benefit of this plan.

- Injectable drugs, except as specified in the Professional Services Benefit of this plan.
- Any drugs or items in excess of the specific limits described above.

**Prostate Cancer Screening:** The Professional Services and Hospital Services laboratory Benefits of this plan will be provided for prostate cancer screening services, if recommended by a physician, a physician's assistant or an advanced registered nurse practitioner.

**Prostheses and Orthotics:** Benefits will be provided for the purchase of braces, splints, orthopedic appliances and other orthotic supplies, and for purchase of a prosthesis for functional reasons when replacing a missing body part, when obtained from a prosthetic and orthotic supply provider. No benefits will be provided for cosmetic prostheses except for necessary external and internal breast prostheses following a mastectomy. Benefits for all custom-made orthotics are limited to one pair per 12 consecutive months. An item ordered before your effective date of coverage will not be provided. An item ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of an item due to normal use or growth of a child will be provided. The Company may elect to provide benefits for a less costly alternative item. For other special equipment, see the Special Equipment and Supplies Benefit of this plan.

**Rehabilitative Services:** The benefits described below will be provided for rehabilitative care when medically necessary to restore and improve function previously normal but lost due to a documented illness or injury, including function lost as a result of congenital anomalies. Illnesses and injuries include, but are not limited to:

- *Illness.* Any documented illness (e.g. stroke, viral infection, or bacterial infection) that occurs during prenatal, perinatal, childhood, adolescence, or adulthood.
- *Injury.* Any documented injury that occurs during prenatal, perinatal, childhood, adolescence, or adulthood.

Benefits will be provided as follows:

- Regular inpatient Hospital Services and Skilled Nursing Facility Benefits will be provided for an inpatient rehabilitative admission for physical (including massage therapy), speech and occupational therapy. Hospital services must be provided in a hospital approved by the Company for rehabilitative services. Benefits will be limited to services rendered within three benefit

years from the date of your first hospital or skilled nursing facility rehabilitative care admission.

- Physical (including massage therapy), occupational, or speech therapy in the office, home, or hospital outpatient department approved by the Company for rehabilitative care. Services must be provided by a provider for physical, occupational, and speech therapy only or a hospital approved by the Company for rehabilitative care. The type and duration of the therapy must be under an attending physician's direction and supervision while you remain under that attending physician's care. Your attending physician must evaluate the therapy treatment at least once every three months and certify that continuing therapy is necessary. After three months, continued therapy must be approved by the Company. The Company bases its decision on the attending physician's evaluations of the treatment and the therapist's progress notes. The Company reviews that information against established medical criteria to determine whether the recommended care will continue to improve function and will be covered. Copays apply to outpatient treatment.
- All treatment must be prescribed by a Selections network provider, except for eligible dependent children living outside the service area.
- You will not be eligible for the Neurodevelopmental Therapy Benefit and this benefit for the same services for the same condition.

No benefits will be provided for custodial care; maintenance therapy; nonmedical self-help; recreational, educational, or vocational therapy; mental disorder care; learning disabilities or developmental delay; chemical dependency rehabilitative treatment; gym or swim therapy; and any other services or supplies specifically excluded under the regular limitations and exclusions of the plan. The plan does not cover ongoing therapy (maintenance therapy) for a given condition after the patient has reached maximum rehabilitation potential, or functional level, or has shown no significant improvement for two weeks, and the initial instruction in a maintenance program is completed.

**Repair of Teeth:** The services of a dentist (D.M.D. or D.D.S.) or a denturist licensed under Title 18 RCW will be provided for repair of accidental injury (trauma) to natural teeth that are whole and functionally sound or have been restored to a sound functional capacity. Benefits will be provided for the treatment of the injury for a period of 12 consecutive months from the date of the injury to a maximum of \$1,000 per occurrence. Services for treatment must begin within 30 days from the date of injury in order for any benefits to be payable for repair of teeth. This benefit is supplemental to any

dental plan you may have. This benefit will not be provided for injury caused by biting or chewing or for dental implants. No other charges of a dentist or denturist will be covered under this plan, except when specifically provided otherwise.

**Skilled Nursing Facility:** The inpatient services and supplies of a skilled nursing facility will be provided for illness, accidental injury, or physical disability. Room and board is limited to the skilled nursing facility's average semiprivate room rate, except where a private room is determined to be medically necessary. Your physician must submit for approval by the Company and periodically review a written treatment plan specifically describing the services to be provided. No custodial care is provided.

**Special Equipment and Supplies:** The following will be provided: casts; ostomy bags and related supplies; catheters; surgical appliances; syringes and needles for allergy injections; dressings medically necessary for wounds, cancer, burns or ulcers; and FDA-approved contraceptive supplies, devices, and implants, requiring a prescription. Formulas for the treatment of phenylketonuria will also be provided as specified in the Payment Schedule under "Phenylketonuria Formulas." Items ordered before your effective date of coverage will not be provided. Items ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be provided. Repair or replacement of items due to normal use or growth of a child will be provided.

**Spinal and Extremity Manipulations:** Benefits will be provided for a combined total of 26 spinal and extremity manipulation visits per benefit year. Multiple spinal and extremity manipulations performed by hand during the same visit will count as one manipulation visit.

**Sterilization Procedures:** Benefits will be provided for sterilization procedures. Reversals of these procedures will not be covered.

**Temporomandibular Joint Disorders (TMJ):** Benefits will be provided for medical services for treatment of temporomandibular joint disorders. A TMJ disorder has one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint. Benefits will be limited to a maximum of \$1,000 per benefit year, not to exceed a lifetime maximum of \$5,000. Copays apply to outpatient services.

"Medical services" for the purpose of this TMJ Benefit mean those services that are: 1) reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and 2) effective for the control or

elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and 3) recognized as effective, according to the professional standards of good medical practice; and 4) not investigational or primarily for cosmetic purposes.

All services must be provided or ordered by your physician. Benefits for all surgical services related to TMJ must be authorized by the Company in writing, in advance. The Company will waive its advance notification requirement for treatment commencing within 48 hours, or as soon as is reasonably possible as determined by the Company, after the occurrence of an accidental injury or trauma to the temporomandibular joint. No other benefits for TMJ will be provided by this plan.

**Tobacco Cessation:** The services of a physician, psychologist, or tobacco cessation provider, will be provided for a tobacco cessation program to a lifetime maximum of \$500. To receive benefits for tobacco cessation, you must complete the full course of treatment. No benefits will be provided under this benefit for inpatient services; vitamins, minerals and other supplements; acupuncture; over-the-counter drugs or prescription drugs prescribed by your covered provider to ease nicotine withdrawal, however, drugs prescribed to ease nicotine withdrawal are covered under the Prescription Drugs Benefit of this plan; books or tapes; or hypnotherapy unless performed by a Selections network provider. No other benefits for tobacco cessation will be provided under this plan.

**Transplants:** The Select Network Plan benefits will be provided for all medically necessary services or supplies related to all transplants, as determined by the Company, as follows:

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

- Heart
- Heart/lung (combined)
- Kidney
- Pancreas
- Kidney/pancreas (combined)
- Islet cell
- Lungs – single /bilateral/lobar
- Liver
- Small bowel
- Small bowel/liver/multivisceral
- Cornea

- Hematopoietic stem cell support. Donor stem cells can be collected from either the bone marrow or the peripheral blood. Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor), or umbilical cord blood (only covered for certain conditions, as specified in this Transplants Benefit).
- Other transplants determined by the Company to be a covered benefit since this plan was issued.

A current list of covered transplants can be obtained by contacting the Company. For more information, call the Company at the number listed in the Customer Service Directory.

**Benefits for all transplants must be authorized by the Company in writing, in advance. Approval will be based on the member's medical condition, the qualifications of the providers, appropriate medical indications for the transplant, and appropriate, proven medical procedures for the type of condition. All transplants must be performed in a facility approved by the Company. If a transplant is not successful, only one retransplant will be covered, subject to the benefit limits specified.**

**Donor Organ Benefits:** Donor organ procurement costs will be covered if the recipient is covered for the transplant under this plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other such medically necessary procurement costs as determined by the Company. Donor benefits will be charged against the recipient's benefit limits.

**Travel Expenses:** Travel and lodging expenses for you and your family will be covered when you are required by the Company to travel 75 miles or more from your residence to the facility where the transplant is received for medically necessary services related to an approved transplant. Benefits will be paid at the level specified for Selections hospitals to a maximum of \$2,500 per transplant episode requiring travel and must be approved in advance by the Company.

**Limitations:** Benefits for transplants will be limited as follows:

- With regard to autologous stem cell support, syngeneic stem cell support, and high-dose chemotherapy associated with autologous stem cell support or syngeneic stem cell support, coverage is available for treatment of the following malignancies/conditions: Non-Hodgkin's lymphoma; Hodgkin's lymphoma; neuroblastoma; acute lymphocytic or non-lymphocytic leukemias; germ cell tumor; multiple myeloma; Ewing's Sarcoma; Wilms Tumor; breast cancer; primary amyloidosis; and other malignancies/conditions determined by the Company to be a covered benefit since this

plan was issued. Autologous stem cell support, syngeneic stem cell support, and high-dose chemotherapy associated with autologous stem cell support or syngeneic stem cell support for conditions other than those listed above or as determined by the Company to be a covered benefit since this plan was issued will not be covered.

- With regard to allogeneic stem cell support and high-dose chemotherapy associated with allogeneic stem cell support, coverage is available for treatment of the following malignancies/conditions: Non-Hodgkin's lymphoma; Hodgkin's lymphoma; neuroblastoma; acute lymphocytic or non-lymphocytic leukemias; chronic myelogenous leukemia; aplastic anemia; severe combined immunodeficiency (not AIDS); Wiskott-Aldrich syndrome; infantile malignant osteopetrosis; homozygous beta-thalassemia; myelodysplastic syndromes; mucopolysaccharidoses; mucopolysaccharidoses; sickle cell anemia; Kostmann's syndrome; leukocyte adhesion deficiencies; x-linked lymphoproliferative syndrome; megakaryocytic thrombocytopenia; other malignancies/conditions determined by the Company to be a covered benefit since this plan was issued. Allogeneic stem cell support and high-dose chemotherapy associated with allogeneic stem cell support for conditions other than those listed above or as determined by the Company to be a covered benefit since this plan was issued will not be covered.

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

- Nonhuman, artificial or mechanical transplants.
- When the recipient is not covered under this plan.
- Investigational procedures.
- Services in a facility not approved by the Company.
- Donor and procurement services and costs incurred outside the United States unless approved by the Company.
- Stem cell support and high-dose chemotherapy associated with stem cell support, except as specified in this Transplants Benefit.
- When donor benefits are available through other group coverage.
- When government funding of any kind is provided.
- Lodging, food, or transportation costs, unless otherwise specified under this plan.

**Vision Care:**

**Eye Examination:** For information about your eye exam coverage, please see the Routine Eye and Hearing Examinations Benefit of this plan.

**Lenses and Frames:** Benefits for lenses and frames will be provided when prescribed by a Selections network physician, or a Selections network optometrist to correct a refractive error.

For lenses and frames obtained from a participating optical provider, the Company will make payment directly to the provider as specified in the following schedule. For lenses and frames obtained from any other optical provider, you will be reimbursed as specified in the following schedule.

Other types of lenses and lens options not listed below are available. If you choose these other lenses and options, you will be responsible for any additional cost.

<b>Lenses, per pair:</b> (for standard plastic or clear glass; maximum of four lenses/two pair every two benefit years)	<b>Allowance per pair:</b>
Single Vision	\$50.00
Basic Line Bifocal	\$80.00
Basic Line Trifocal	\$95.00
Progressive	\$95.00
Lenticular, Aphakic or Aniseikonic, Variable asphericity (external lens requiring a frame)	\$155.00
Contacts	\$120.00
<b>Frames:</b> (maximum of two every two benefit years)	\$90.00

This benefit is not subject to any deductible requirements.

# WHEN WON'T THINGS BE COVERED?

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## LIMITATIONS AND EXCLUSIONS

***No benefits are provided for the following, or for any direct complications or consequences thereof, unless specifically stated otherwise below or unless specifically provided for in the “Benefits” section.***

- Acupuncture, except as specifically provided in the Acupuncture and Chemical Dependency Benefits in the “Benefits” section.
- Addiction to or abuse of drugs, alcohol or any other chemical substance whether legal or illegal, except as specifically provided in the Chemical Dependency Benefit in the “Benefits” section.
- Ambulance services, except as specified in the Ambulance Services Benefit in the “Benefits” section.
- Any treatment or services in connection with transsexualism.
- Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program, except for facilities that are included on the Company's list of participating providers, and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Government facilities outside the service area will not be covered (except as required by law for emergency services).
- Charges for services or supplies that are above the allowed amount as defined in the “Definitions” section, except for medical emergencies.
- Charges that in the absence of this plan there would be no obligation to pay.
- Cosmetic surgery and supplies (including drugs) and the treatment of any direct or indirect complications of such surgery, except: 1) when related to an illness or injury; 2) for congenital anomalies; and 3) for reconstructive breast surgery following mastectomies, to the extent required under federal and state law as follows: a) reconstruction of the diseased breast; b) reconstruction of the nondiseased breast to produce a symmetrical appearance; and c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas.
- Custodial care.
- Dental services, except as specified in the Repair of Teeth and Hospitalization for Dental Services Benefits in the “Benefits” section.
- Drugs, except as specifically provided in the Prescription Drugs Benefit in the “Benefits” section. Inpatient benefits are provided for drugs in a hospital or skilled nursing facility. Preventive

injections or immunizations will be covered only as specifically provided in the Preventive Care Benefit in the “Benefits” section. FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment: 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. (For definitions of “off-label,” “standard reference compendia,” and “peer-reviewed medical literature,” please see the “Definitions” section.) No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.

- Dyslexia treatment, except as specified in the Neurodevelopmental Therapy Benefit in the “Benefits” section; visual analysis, therapy or training; orthoptics.
- Hearing aids, except as specifically provided in the Hearing Aid Benefit in the “Benefits” section; this exclusion does not apply to cochlear implants.
- Home medical equipment, special equipment or supplies, prostheses, orthopedic or surgical appliances, braces, or foot care appliances, except as specifically provided in the Home Medical Equipment, Prostheses and Orthotics, and Special Equipment and Supplies Benefits in the “Benefits” section; Home Medical Equipment provided by a home health or hospice agency may also be provided as specified in the “What Else Do I Need To Know?” section.
- Hospitalization for conditions for which the member is not usually hospitalized, such as common colds, minor cuts or bruises, removal of small tumors, and similar minor conditions.
- Injuries sustained while practicing for or competing in a professional or semiprofessional athletics contest. “Semiprofessional athletics” contest means an athletic activity for gain or pay, that requires an unusually high level of skill and a substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.
- Investigational services or supplies.
- In-vitro fertilization, artificial insemination, embryo transfer, or any other artificial means of conception, including any expenses for fertility drugs related to the above listed procedures. However, a pregnancy resulting from such conception will be covered under the regular benefits of this plan, as applicable.
- Maintenance therapy, except as specifically provided in the Neurodevelopmental Therapy and Rehabilitative Services Benefits in the “Benefits” section.
- Marital counseling; family counseling, except as specifically provided in the Mental Health Benefit in the “Benefits” section.

- Mental health, including mental health treatment for anorexia nervosa, bulimia or other eating disorders, except as specifically provided in the Mental Health Benefit in the “Benefits” section.
- Neurodevelopmental therapy, except as specifically provided in the Neurodevelopmental Therapy Benefit in the “Benefits” section.
- Nursing services that are not included in a covered facility’s basic charge, except as specifically provided in the Professional Services, Home Health, and Hospice Benefits in the “Benefits” section. Private duty nursing or hourly nursing charges are not covered.
- Occupational injury or disease (including any arising out of self-employment).
- Over-the-counter contraceptive supplies and devices.
- Physical or psychiatric examinations or psychological testing for the purpose of obtaining or continuing employment, licensure, legal proceedings, insurance, school admission, or sports activities, or which are conducted for purposes of medical research.
- Preventive care, except as specifically provided in the Preventive Care Benefit in the “Benefits” section.
- Refractive surgery including radial keratotomy, Lasik, or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.
- Rehabilitative care, including speech therapy, physical therapy (including massage therapy) or occupational therapy, except as specifically provided in the Home Health, Hospice, and Rehabilitative Services Benefits in the “Benefits” section.
- Routine eye and hearing examinations, except as specifically provided in the Routine Eye and Hearing Examinations Benefit in the “Benefits” section.
- Services and supplies not medically necessary (as defined in the “Definitions” section) for treatment of an illness or injury, unless otherwise listed as covered.
- Services or supplies that are payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance when such contract or insurance is issued to or makes coverage available to the member. Any benefits provided by or advanced by the Company contrary to this exclusion are provided solely to assist the member. By paying such benefits, the Company is not acting as a volunteer and is not waiving any right to reimbursement or subrogation. When no-fault insurance is available and benefit payments have not been exhausted or denied for reasons other than the medical treatment being: (a) not reasonable; (b) not necessary; (c) not related to the accident; or (d) not incurred within three years of the accident, it will be the

- member's responsibility to pursue their coverage through the no-fault carrier to obtain the available limits of the no-fault coverage.
- Services provided by a family member. A "family member" means the member's spouse, parent, or child.
  - Services provided by the group or any of its employees or agents.
  - Spinal and extremity manipulations, except as specified in the Spinal and Extremity Manipulations Benefit in the "Benefits" section.
  - Stem cell support and high-dose chemotherapy associated with stem cell support will be provided only under the Transplants Benefit in the "Benefits" section. No other benefits related to stem cell support and high-dose chemotherapy associated with stem cell support will be provided under this plan.
  - Surgery or treatment for sexual dysfunction/impotence, except as determined by the Company.
  - Surgery or treatment for transsexualism.
  - Surgery (including reversals), treatment, programs or supplies intended to result in weight reduction, regardless of diagnosis.
  - Treatment and any appliances used in connection with temporomandibular joint disorders, malocclusions, myofascial pain syndrome, or other abnormalities of the jaw, except as specifically provided in the Temporomandibular Joint Disorders Benefit in the "Benefits" section.
  - Treatment of any condition caused by or resulting from active participation in the armed forces in a war or insurrection.
  - Treatment of any condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.
  - Eyeglasses and contact lenses and the fitting thereof, except for the first intraocular lenses following cataract surgery and except as specifically provided in the Vision Care Benefit in the "Benefits" section.
  - Visits or consultations that are not in person, including but not limited to any telephone, Internet, or other electronic communication (except tele-medicine in remote locations, as approved by the Company), whether initiated by the member or the member's provider.

## HOW DO I FILE A CLAIM?

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**In the Service Area:** Be sure to present your Select Network Plan member identification card when receiving treatment. Filing claims for services of providers who have contracted with our Company is not necessary. If you receive a bill from your provider or hospital, please verify with the provider or hospital that the Company has been billed. At the time of service you should inform your provider about copays that are required on your plan. Arrangements for paying copays should be handled directly between you and your provider.

The information listed below is for medical emergencies only and for dependent children living outside the service area.

**Outside the Service Area:** The Company participates with other Blue Cross and/or Blue Shield Licensees in a program called BlueCard to process claims for care received outside the service area. If you receive care within the service area of a Blue Cross and/or Blue Shield Licensee, other than the Company, you may be able to take advantage of agreements between providers and the on-site Blue Cross and/or Blue Shield Licensee. By using your member identification card, Preferred Plan and/or participating providers with those Licensees can file your claim with the on-site Blue Cross and/or Blue Shield Licensee. The Licensee will then send your claim electronically to the Company. We will inform the on-site Licensee of benefit information and the Licensee will then pay the provider as appropriate. When your claim is processed, you will receive an explanation of claims processing that will specify any amount you owe the provider. You will not be responsible for any balances beyond any deductible, copay, and coinsurance amount. You will also, most likely, avoid having to pay for your entire service up front.

When you obtain health care services through the BlueCard Program outside the Service Area, the amount you pay for covered services is usually calculated according to the lower of:

- The billed charges for the services, or
- The "negotiated price" that the other Blue Cross and/or Blue Shield Licensee passes on to us.

The negotiated price will, most often, be a simple discount which reflects the actual price paid by the other Blue Cross and/or Blue Shield Licensee. But sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements, and non-claim transactions, with the Licensee's providers or provider groups. The negotiated price may also be billed charges reduced to reflect an average expected savings with the

Licensee's providers or provider groups. This price may result in a greater variation from the actual price than will the estimated price. The negotiated price may be prospectively adjusted to correct for past overestimation or underestimation of prices. However, the amount you pay is considered a final price.

In addition, state laws may require a small number of Licensees to use a method of calculating the amount you are responsible for paying that does not reflect the entire savings realized, or expected to be realized, on a particular claim for covered services or to add a surcharge. If you receive covered services in one of those states, the amount you are responsible for paying will be calculated using the individual state's statutory requirements.

You are entitled to benefits for covered health care services received by you either inside or outside the Service Area. Due to variations in the Blue Cross and/or Blue Shield Licensee medical practice protocols, you may receive benefits for some health care services obtained outside the Service Area, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the Service Area. But in no event will you be entitled to benefits for health care services that are specifically excluded or limited from coverage under this Licensee.

If you see a provider that is not a Preferred Plan or participating provider with an on-site Blue Cross and/or Blue Shield Licensee, you must submit your own claims. See the "How To Submit Other Claims" provision for information on how to file claims under these circumstances.

"Licensee" means an entity licensed by the Blue Cross and Blue Shield Association to use the Blue Cross® and/or Blue Shield® Service Marks. A Licensee may be a Primary Licensee or its licensed affiliate, or other entity that is licensed by the Association to use Marks outside the United States.

**BlueCard Worldwide®:** The Company participates in BlueCard Worldwide. With BlueCard Worldwide, you have access to inpatient and outpatient hospital care and physician services when you're traveling or living outside the United States, as well as medical assistance and claims support services.

When you need health care outside of the United States or its territories, follow these simple steps:

- Always carry your current member identification card.
- If you need emergency medical care outside the United States, go to the nearest hospital.
- If you are admitted, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.

- For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide hospital or make an appointment with a physician. BlueCard Worldwide Service Center staff are available to assist you 24 hours a day, 7 days a week.
- You will only be responsible for out-of-pocket expenses such as any applicable deductible, copays, coinsurance and non-covered services for your inpatient care at a participating hospital upon notification of the BlueCard Worldwide Service Center. For inpatient hospital care, outpatient hospital care or physician services by a Recognized provider, you will be responsible for paying the hospital or physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide Service Center for reimbursement of covered services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide program at [www.bcbs.com](http://www.bcbs.com).

## **HOW TO SUBMIT OTHER CLAIMS**

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

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

All claims must be submitted within 15 months of the date of service. Claims not submitted within this time limit will not be paid.

## **RECOVERY OF PAYMENT**

Payment of a claim due to error or incomplete or inaccurate information does not constitute a waiver by the Company of any provisions, limitations, or exclusions of this plan, or a waiver of the Company's right to recover such payment when the error is discovered or when complete or accurate information is received.

## **BENEFITS NOT TRANSFERABLE**

Only you are entitled to benefits under this plan. These benefits are not assignable or transferable to anyone else and you (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits to any person, corporation, or entity. Any attempted assignment, transfer, or delegation of benefits shall be deemed null and void and will not be binding on the Company. No member may assign, transfer, or delegate any right of representation or collection other than to legal counsel directly authorized by the member on a case-by-case basis.

## **CHECKUP HOTLINE**

We are confident that the vast majority of our subscribers and providers are careful to ensure the accuracy of their health care claims. However, we also know that irregularities can occur, sometimes intentionally. And this means higher costs for all of us for coverage and health care. Use the **CHECKUP Hotline** to report suspected fraud or abuse in the use of your health care benefits; the number is 1-800-922-4325. Call to report such things as: an ineligible person using someone else's member ID card; charges that don't reflect actual treatment; a person sending in false claims for services; or someone using false eligibility information. Your call will be held in strict confidence. Please help us to hold down health care costs.

## **CLAIM REVIEW AND APPEAL**

This section describes claim review and appeal procedures for the coordinated care plans. Your medical claims should be sent to the Company. The address and customer service telephone numbers are listed in the Customer Service Directory.

Your claim will fall within the following categories:

- Your request for benefits before a service or supply is received, including a prior authorization or precertification, is considered a *preservice* claim.
- A request for coverage for continuation of services previously approved by the health plan as an ongoing course of treatment or

to be provided over a certain period of time is considered a *concurrent care* claim.

- An urgent request for coverage for medically necessary services is considered an *urgent* claim.
- A request for benefits after a service or supply is received is considered a *postservice* claim.

When you submit a *postservice* claim, the Company will notify you of its decision within 30 days of receiving your claim for benefits. When you submit a *preservice* claim, the Company will notify you of its decision within 15 days. If special circumstances require more time, the review period may be extended up to an additional 15 days. You will be notified of this extension prior to the end of the initial review period. In addition, if the Company needs additional information, from you and/or your provider, prior to rendering a decision, you will be notified prior to the expiration of the initial review period. You will have an additional 45 days to provide the requested information. After the 45-day period, the Company will make a decision regarding benefits based on the information received.

If your claim is denied, the Company will notify you in writing of the specific reasons for the denial, your right to appeal, and your right to obtain copies of documentation related to the decision, without charge.

An urgent claim process is available for *preservice* and *concurrent* claims. It applies when:

- You or your physician reasonably believe that timing of the regular review process described above could jeopardize your life, health, or ability to regain maximum function, or
- A physician familiar with you and your medical condition believes that timing of the regular review process described above would subject you to severe pain that cannot be controlled adequately without the care that is being considered.

The urgent claim process that would apply in either of these situations would make the claim an *urgent* claim. In the case of an *urgent preservice* claim, the Company will notify you of its decision within 72 hours. For *urgent concurrent* claims, the Company will notify you of its decision within 24 hours.

If your claim is denied, you may be able to resolve the denied claim without a formal appeal by calling the Company and discussing the situation. If the claim is not resolved with a telephone call (informal review process), you may file a formal appeal. You (or your legal representative) may file an appeal within 180 days after receiving notification of the claim denial. Your appeal to the Company may be in writing or may be made orally by calling the Company's customer service number. You must include the reason for your appeal and

may include any information or documentation that will be relevant to the review.

The Company will review the appeal and render a decision. In reviewing your appeal, the Company will apply the terms of the plan and will use its discretion in interpreting the terms of the plan. The Company will notify you of its decision in writing. You will be offered two levels of appeal with the decisions made by individuals not involved in prior reviews. The Company will decide your *postservice appeal* within 30 days for each level of appeal. For *preservice* or *concurrent appeals*, the Company will decide your appeal within 15 days for each level of appeal. However, if your appeal is related to an *urgent* claim, the timeframe noted above for the *urgent* claim process will be followed. The Company will provide you with its decision in writing. If your appeal is denied, the Company's written decision will indicate the specific plan provision and, if appropriate, the medical criteria on which the decision is based, will advise you of your right to obtain copies of documentation related to the decision, without charge, and information regarding any additional appeals or other forums available to you.

If you continue to remain dissatisfied with the denial (or partial denial) decision, following the second level of appeal determination, you or your designated representative, may voluntarily appeal, within 180 days of receipt of the second appeal denial, to the Regence BlueShield Appeals Committee for Boeing employees. Forwarding your appeal to the Regence BlueShield Appeals Committee is voluntary. You will be notified by the Company of the date, time, and location of the Committee's meeting and the right to be present and include others if you choose.

**What You Can Do If Your Appeal Is Denied:** If your appeal is denied, you may bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, except as otherwise provided in an insured contract, you must bring any legal action within 180 days after the decision on appeal of your claim for benefits or eligibility, or expiration of time to take an appeal if no appeal is taken. A post-denial review of your appeal will not extend the time period for commencing legal action.

# WHAT ELSE DO I NEED TO KNOW?

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## RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Coverage under the plan will not be provided for any medical (or dental and vision, if applicable) or prescription drug expenses you incur for treatment of an injury or illness if the costs associated with the injury or illness may be recoverable from any of the following:

- A third party;
- Worker's compensation; or
- Any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to you, whether or not you make a claim under such coverage.

**Advancement of Benefits:** If you have a potential right of recovery for illnesses or injuries from a third party who may have legal responsibility or from any other source, benefits may be advanced pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, you agree that the plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the injury or illness for which benefits under the plan have been provided.
- In addition to the plan's right of reimbursement, the Company may choose instead to achieve the plan's rights through subrogation. The Company is authorized, but not obligated, to recover any benefits paid under the plan directly from any party liable to you, upon mailing of a written notice to the potential payer, to you or to your representative.
- The plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the member and/or any third party or the recovery source. The plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
  - 1) The third party or third party's insurer admits liability;
  - 2) The health care expenses are itemized or expressly excluded in the recovery; or

- 3) The recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the plan.
- Reimbursement or subrogation under the plan will not be reduced due to your not being made whole.
  - You may be required to sign and deliver all legal papers and take any other actions requested to secure the plan's rights (including an assignment of rights to pursue your claim if you fail to pursue your claim of recovery from the third party or other source). If you are asked to sign a trust agreement or other document to reimburse the plan from the proceeds of any recovery, you will be required to do so as a condition to advancement of any benefits.
  - You must agree that nothing will be done to prejudice the plan's rights and that you will cooperate fully with the Company, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Company of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
    - 1) The filing of a lawsuit;
    - 2) The making of a claim against any third party;
    - 3) Scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
    - 4) Intent of a third party to make payment of any kind to your benefit or on your behalf and that in any manner relates to the injury or illness that gives rise to the plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
  - You and/or your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to your benefit or on your behalf that in any manner relates to the injury or illness giving rise to the plan's right of reimbursement or subrogation, until the plan's right is satisfied or released.
  - In the event you and/or your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any illness or injury may be recovered through legal action.
  - Any benefits provided or advanced under the plan are provided solely to assist you. By paying such benefits, neither the plan nor the Company is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

**Motor Vehicle Coverage:** If you are involved in a motor vehicle accident, you may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, this right of reimbursement and subrogation provision still applies.

**Workers' Compensation:** Here are some rules which apply in situations where a workers' compensation claim has been filed:

- You must notify the Company in writing within five days of any of the following:
  - 1) Filing a claim;
  - 2) Having the claim accepted or rejected;
  - 3) Appealing any decision;
  - 4) Settling or otherwise resolving the claim; or
  - 5) Any other change in status of your claim.
- If the entity providing workers' compensation coverage denies your claim and you have filed an appeal, benefits may be advanced for covered services if you agree to hold any recovery obtained in a segregated account for the plan.

**Fees and Expenses:** Neither the plan nor the Company is liable for any expenses or fees incurred by you in connection with obtaining a recovery. However, you may request that a proportional share of attorney's fees and costs be paid at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the plan. The Company has discretion whether to grant such requests.

**Future Medical Expenses:** Benefits for otherwise covered services may be excluded, as follows:

- When you have received a recovery from another source relating to an illness or injury for which benefits under the plan have been previously paid.
- Until the total amount excluded under this provision equals the third-party recovery.

The amount of any exclusion under this provision, however, will not exceed the amount of benefits previously paid in connection with the illness or injury for which the recovery has been made.

## **INDIVIDUAL BENEFITS MANAGEMENT**

For certain illnesses or injuries, our Individual Benefits Management staff will work with you and your provider to determine the treatment options that will provide the most cost-effective or beneficial care in your specific case. In some instances, the Individual Benefits Management staff may authorize benefits that would not normally be covered under this plan; such authorization must be received in advance of the service being provided. The final decision on the course of treatment will rest with you and your provider.

When provided at equal or lesser cost, the benefits of this plan, including Home Medical Equipment provided by a home health or hospice agency, will be available for home health care instead of

hospitalization or other inpatient care when furnished by a licensed home care agency or by a home health or hospice agency that is covered under this plan. Substitution of less expensive or less intensive services will be made only with your consent and when recommended by your physician or health care provider and will be based on your individual medical needs. A written treatment plan may be required by the Company. Coverage will be limited to the maximum benefit payable for hospital or other inpatient expenses under this plan and will be subject to any applicable deductible, coinsurance and plan limits. These benefits will only be provided when your condition is serious enough to require inpatient care and you could qualify for the inpatient benefits of this plan; no benefits will be provided for custodial care.

## **COORDINATION OF BENEFITS**

### **How Claims Are Paid When You Have Duplicate Coverage**

*This section describes coordination of benefit rules for the Medical Plan.*

Plans that offer medical benefits follow certain rules when there is duplicate coverage. For example, if both you and your spouse are working, you or your family members might have duplicate coverage. That is, one or more of you might be enrolled in more than one group health care plan. Other coverage includes, whether insured or uninsured, another employer's group benefit plan, another arrangement of individuals in a group, Medicare (to the extent allowed by law), individual insurance or health coverage, and insurance that pays without consideration of fault.

If you or your covered dependents have duplicate medical coverage, the two plans must coordinate their benefits to determine which plan will be responsible for paying which part of the bill. In this coordination of benefits, one insurer will be considered primary (the plan that considers the charges first) and the other will be considered secondary (the plan that considers the charges second). When you file a claim, it is your responsibility to know which plan is primary and which plan is secondary for you and your covered dependents.

**When the Medical Plan is primary**, this plan will pay its benefits first and without regard to any benefits that may be payable under the secondary plan.

**When the Medical Plan is secondary**, this plan will pay the difference between the benefits paid by the primary plan and what this plan would have paid had it been primary.

## **Determine Whether the Plan Is Primary or Secondary**

When determining whether this health care plan is primary or secondary, this plan applies the following rules. A plan is considered primary when:

- It has no order of benefit determination rules.
- It has benefit determination rules that differ from coordination of benefit rules under state regulations or, if not insured, that differ from these rules.
- All plans that cover an individual use the same coordination of benefit rules, and under those rules, the plan is primary.

If the aforementioned rules do not determine which group plan is considered primary, this plan applies the following coordination of benefit rules:

1. A plan that covers a person as an employee, retired employee, member, or subscriber pays before a plan that covers the person as a dependent.
2. A plan that covers a person as an active employee or dependent of an active employee is primary. The plan that covers a person as a retired, laid-off, or other inactive employee or as a dependent of a retired, laid-off, or other inactive employee is secondary.
3. If a dependent child is covered under both parents' group plans, the child's primary coverage is provided through the plan of the parent whose birthday comes first in the calendar year, with secondary coverage provided through the plan of the parent whose birthday comes later in the calendar year.
4. If a dependent child's parents are divorced or separated and a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of coverage, the following guidelines are used:
  - a. The plan of the parent with custody pays benefits first.
  - b. The plan of the spouse of the parent with custody pays second.
  - c. The plan of the parent without custody pays third.
  - d. The plan of the spouse of the parent without custody pays fourth.
5. If none of the aforementioned rules establishes which group plan should pay first, then the plan that has covered the person for the longest period is considered the primary plan of coverage.
6. Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), always is secondary to other coverage, except as required by law.
7. If you or an eligible dependent is confined to a hospital when first becoming covered under this plan, this plan is secondary to any plan (including a Company-sponsored health care plan) already covering you or your dependent for the eligible expenses related to

that hospital admission. If you or your dependent does not have other coverage for hospital and related expenses, this plan is primary.

### **If You Are Covered by Two Boeing-Sponsored Plans**

Benefits under a Company-sponsored medical are not coordinated with benefits paid under any other group plan offered by the Company, except as described below. You can receive benefits from only one Company-sponsored medical or dental plan. However, when dental services performed by a licensed dentist also are covered under the medical plan, the dental plan pays its benefits first and the medical plan is secondary.

### **If You Are Covered by Medicare and This Plan**

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or dependent of an active employee. Medicare is primary in most other circumstances.

Treatment of end-stage renal disease is covered by the Medical Plan for the first 30 months following Medicare entitlement due to end-stage renal disease, and Medicare provides secondary coverage. After this 30-month period, Medicare provides primary coverage, and the Medical Plan provides secondary coverage.

### **Claim Administration**

The service representative has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

## **COVERAGE UNDER A PRIOR PLAN**

If you were covered under a prior plan underwritten or administered by the Company before coverage under this plan began, the following will apply:

- For dependents living outside the service area who have a deductible, you will be allowed to credit your eligible deductible expenses accumulated during a benefit year or during the last three months of the prior benefit year to your new deductible, except if you are transferring from Boeing's Traditional Medical Plan.
- Any benefits used under a prior Boeing Select Network Plan during that benefit year will be charged against this plan's maximums for that same benefit year. Any benefits used under a prior Boeing Select Network Plan and not reinstated will also be charged to the benefit maximums of this plan.

## **WHEN YOU ARE NO LONGER ELIGIBLE FOR COVERAGE**

If you or any of your dependents are no longer eligible for coverage under this plan, health protection with the Company is available as described below. If coverage under this plan terminates for your entire group and the group transfers its plan to another Contract with the Company, to another carrier or to another self-insured plan, and you or your dependents become covered under the new plan, the conversion options described below do not apply.

**Certificate of Health Coverage:** When your coverage under this plan ends, The Boeing Company automatically will send you a "Certificate of Health Coverage." The Boeing Company will also issue a certificate, upon your request, within 24 months of cessation of coverage. The certificate will provide information about your length of coverage under this plan. Please verify the accuracy of the information when you receive your certificate. If you do not receive a certificate or misplace the one you receive, please contact the Boeing Service Center through Boeing TotalAccess at 1-866-473-2016 (TTY/TDD 1-800-755-6363) or [www.boeing.com/express](http://www.boeing.com/express).

**Medicare Supplement:** Persons who are eligible for Medicare may be eligible for coverage under one of the Company's Medicare Supplement plans. To be eligible for continuous coverage, the Company must receive the person's application within 31 days following termination of coverage under this plan. If a person applies for Medicare Supplement coverage within six months of enrolling in Medicare Part B coverage, no health statement will be required. After the six-month enrollment period, a health statement may be required. Benefits and rates under the Medicare Supplement plan will be substantially different from this plan.

**Conversion Plan:** For persons under age 65 who are not eligible for Medicare, coverage will be available under one of the Company's conversion plans. To be eligible, the Company must receive the person's application within 31 days after termination of coverage under this plan. A health statement will not be required. The benefits of the conversion plan will be the standard individual medical and hospital benefits then being issued by the Company for people converting from another plan; rates will be higher than for this plan, and benefits may be substantially less. Any new dependents added to the conversion plan after the subscriber's effective date will have to satisfy the waiting periods of the conversion plan. By enrolling on a conversion plan, you may lose the right to enroll under one of the Company's marketed individual plans without submitting a health questionnaire.

**Individual Plan:** Instead of applying for one of the conversion plans described above, a person not eligible for Medicare may also apply for coverage under one of the Company's marketed individual plans. To be eligible, the person must submit a completed application form and health questionnaire, if applicable, and must be accepted by the Company for coverage. Benefits and rates under the individual plan may be substantially different from this plan.

## **LEAVING OUR SERVICE AREA**

If you move to an area served by another Blue Cross and/or Blue Shield plan, your coverage may be transferred to the plan serving your new address. The other Blue Cross and/or Blue Shield plan must offer you at least its conversion contract, which does not require a medical examination or health statement. If you accept the new conversion contract, you will receive credit for the length of your enrollment with the Company toward any of the new plan's waiting periods. The rates and benefits available from your new carrier may vary significantly from those offered by our Company.

You may also be offered other types of coverage with the Blue Cross and/or Blue Shield plan serving your new location; please be aware that such contracts may require a medical examination or health statement to exclude coverage for preexisting conditions, and may not apply time enrolled with our Company to the new waiting periods. Contact our office when you are leaving our service area and we will assist you in transferring to a Blue Cross and/or Blue Shield plan in your new location.

## **RELEASE OF MEDICAL INFORMATION**

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

- Any provider to disclose to the Company any medical information it requests in accordance with state and federal law.
- The Company to examine your medical records at the offices of any provider.
- The Company to release to or obtain from any person or organization any information necessary to administer your benefits.
- The Company, in the exercise of its subrogation rights, and persons acting on behalf of the Company to release any information about an accident, your injuries, and the benefits and medical services you received to any person who may be liable to you or to the Company, and to such person's insurer.
- The Company to examine your employment records in order to verify your eligibility.

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

## DEFINITIONS

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

**Allowed Amount:** The allowed amount shall mean one of the following:

- ***Selections Network Plan, Preferred Plan, or Participating Providers Inside The Service Area, Who Have Agreements With The Company:*** For services or supplies covered under this plan, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between the Company and the provider. These providers agree to seek payment from the Company when they furnish covered services to you. You will be responsible only for any applicable deductible, copays, coinsurance, and charges in excess of the stated benefit maximums, if any, and for charges for services and supplies not covered under this plan.
- ***Preferred Plan or Participating Providers Outside The Service Area Who Have Agreements With Other Blue Cross and/or Blue Shield Licensees:*** The allowed amount is determined as stated in the Outside the Service Area provision of the "How Do I File A Claim?" section.
- ***Recognized Providers Who Do Not Have Agreements With The Company Or Another Blue Cross and/or Blue Shield Licensee:***
  - 1) Inside the service area, the allowed amount will be equivalent to billed charges.
  - 2) When services outside the service area are not received through the BlueCard program, the allowed amount is determined, at the Company's option, as either the negotiated price used by the Blue Cross and/or Blue Shield Licensee in that area for its contracted providers or an amount determined by an independent entity selected by the Company.
  - 3) When you seek services from providers that do not have agreements with the Company, your liability is for any amount above the allowed amount, and for any applicable deductible, coinsurance, copays, amounts in excess of stated benefit maximums, if any, and charges for services and supplies not covered under this plan.

The Company reserves the right to determine the amount allowed for any given service or supply.

You will be responsible for the total billed charges for services or supplies in excess of lifetime or per benefit year benefit maximums, if any, and for charges for any other service or supply not covered under this plan, regardless of the provider rendering such service or supply.

**Benefit Year:** The benefit year July 1 through December 31, 2009. Effective January 1, 2010, the benefit year is January 1 through December 31.

**Benefits:** Payment by the Company for services and supplies covered under this plan.

**Chemical Dependency:** An illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under RCW 69.50 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 the 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.

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

**Company:** Regence BlueShield.

**Copay:** The amount, in addition to the rate, which you are required to pay for certain services and supplies provided under this plan. The copay will be the copay amount stated in the "What Do I Have To Pay For?" and "Benefits" sections of this plan, or the allowed amount, whichever is less. You are responsible for the payment of any copay directly to the provider of the service or supply.

**Cosmetic:** Services and supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance.

**Custodial Care:** Care that, as determined by the Company, is designed primarily to assist you in activities of daily living, and which is not primarily provided for its therapeutic value in treatment of an illness or injury, including institutional care that serves primarily to support self-care and provide room and board, and can be provided by people without medical or paramedical skills. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of

meals or special diets, and supervision of medications that are ordinarily self-administered.

**Dental Services:** Services and supplies (including drugs) provided to diagnose, prevent, or treat diseases or conditions of the teeth and supporting tissues, including treatment that restores the function of the teeth.

**Dependent:** A person listed as a dependent of the subscriber, who is eligible, and covered under the plan.

**Exclusive Provider Organization (EPO):** A health benefits program in which the member receives benefits only within this provider network except for medical emergencies.

**Hospital:** An accredited general hospital that is a provider covered under this plan.

**Inpatient:** A person confined overnight in a hospital or other facility as a regularly admitted bed patient to whom a charge for room and board is made in accordance with the hospital's or facility's standard practice.

**Inpatient Rehabilitation Admission:** An inpatient admission to a Company approved facility specifically for the purpose of receiving speech, physical, or occupational therapy in an inpatient setting.

**Investigational Service Or Supply:** A service or supply (including but not limited to drugs, devices, and other items) that is determined by the Company to be either: classified as experimental and/or investigational by the national Blue Cross Blue Shield Association or the Company, or is on an investigational protocol, unless approved in writing in advance by the Company.

The national Blue Cross Blue Shield Association's determination is based on the following criteria:

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes (which means significant measurable improvement in length of life, ability to function, or quality of life);
- The technology must improve the net health outcome (as defined above);
- The technology must be as beneficial as any established alternatives;
- The improvement must be attainable outside the laboratory or clinical research setting; and
- Items must have been approved by the U.S. Food and Drug Administration (FDA) as being safe and efficacious for general marketing, and permission must have been granted by the FDA for commercial distribution.

If the Company receives a fully documented claim or request (see below) for preauthorization related to a service, supply, drug, device, or other item, a decision will be made and communicated to you within 15 days. If a decision is made to deny benefits, the written denial will identify (by job title only, unless requested otherwise) the individual making the decision. The written denial will contain the basis for the decision and an explanation of your right to appeal the decision.

You may also have a right to an urgent appeal. See the Claim Review and Appeal provision in the “How Do I File A Claim?” for additional information on procedures.

“Fully documented” means that all of the following are included with a claim or request:

- A hard copy of your clinical history.
- All reasonably available relevant medical literature (including peer-reviewed articles) that support or relate to the claim or request.
- If your request is for a drug or supply, the booklet describing its function, indications, and FDA approval notification, if the drug is not FDA-approved for a specific condition, documentation showing whether the drug is Group A, B, or C, with supporting documentation.
- If the treatment or procedure is part of a research protocol, copies of the research protocol and any informed consent that you have signed or will be asked to sign in connection with the treatment or procedure that is the subject of the claim or request, and copies of all documents created by the institutional review board of the institution where the treatment or procedure will be performed that relate to the treatment or procedure, including all supporting documentation.

**Maintenance Care:** Care provided by licensed professionals or other medical staff that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

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

**Medically Necessary:** Means health care services or supplies that a physician or other health care provider exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and
- Not primarily for the convenience of the member, physician or other health care provider, and not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member'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 and the views of physicians practicing in relevant clinical areas and any other relevant factors."

**Member:** A person entitled to benefits under this plan.

**Mental Health:** Only those diagnoses included in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, (except as specified in the Chemical Dependency Benefit and except as otherwise excluded under this plan), regardless of the cause of the disorder, including whether or not the condition has an organic/physiologic or a functional basis.

**Off-Label:** The prescribed use of a drug which is other than that stated in its FDA-approved labeling.

**Participating Provider:**

- Inside the service area, a provider whose name is included in the current list of participating providers for this plan as prepared by the Company and provided to the group and who has entered into a current participating agreement with the Company.
- Outside the service area, a provider who has entered into a current participating agreement with the local Blue Cross and/or Blue Shield plan and who is acting within the scope of that provider's license, who belongs to a category of providers whose services or supplies would be covered under this plan as benefits if furnished inside the service area.

**Peer-Reviewed Medical Literature:** Scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.

**Physician:** A licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.), or a licensed doctor of naturopathic medicine (N.D.), who is a provider covered under this plan.

**Preferred Plan Provider:**

- Inside the service area, a provider whose name is included in the current list of Preferred Plan providers for this plan as prepared by the Company and provided to the group and who has entered into a current Preferred Plan provider agreement with the Company.
- Outside the service area, a provider who has entered into a current Preferred Plan provider agreement with the local Blue Cross and/or Blue Shield plan and who is acting within the scope of that provider's license, who belongs to a category of providers whose services or supplies would be covered under this plan as benefits if furnished inside the service area.

**Prescription Drug:** Inside the United States, any state or federal legend drug approved by the Food and Drug Administration (FDA), including compounded products with active ingredients approved by the FDA requiring a prescription, and dispensed by a licensed pharmacist. Outside the United States, any drug equivalent to a state or federal legend drug approved by the FDA.

**Recognized Provider:**

- Inside the service area, a provider who is acting within the scope of that provider's license, who is not a Selections, Preferred Plan, or participating provider, or who belongs to a category of providers to whom Selections, Preferred Plan or participating agreements are not offered but for whose services this plan provides certain benefits.
- Outside the service area, a provider who is acting within the scope of that provider's license, who belongs to a category of providers that do not have Preferred Plan or participating provider agreements with Blue Cross and/or Blue Shield licensees, other than the Company, but whose services or supplies would be covered under this plan as benefits if furnished inside the service area. The recognized provider must have qualifications and a license or certification required for the comparable provider category inside the service area.

- For medical emergencies inside or outside the service area, a recognized provider means a provider who is not a Selections, Preferred Plan, or participating provider.

**Reconstructive:** Services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but it may also be done to approximate a normal appearance.

**Select Network Plan Provider:** A provider whose name is included in the current list of Selections network providers for this plan as prepared by the Company and provided to the group and who has entered into a current Selections network provider agreement with the Company. The Regence Select Network uses the Selections network of providers.

**Service Area:** Washington counties of King, Pierce, Snohomish, Lewis, Cowlitz, Wahkiakum, Thurston, Yakima, Walla Walla, Grays Harbor, Pacific, Clallam, Columbia, Mason, Jefferson, Kitsap, Klickitat, Skagit, Whatcom, Skamania, San Juan, Island; and any other areas designated by the Company. Please check our Web site at [www.myRegence.com](http://www.myRegence.com) for up-to-date information.

**Standard Reference Compendia:**

- The American Hospital Formulary Service-Drug information;
- The American Medical Association Drug Evaluation;
- The United States Pharmacopoeia-Drug Information; or
- Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

**Subscriber:** The active employee or retiree of the group who is eligible for coverage under this plan.

## **WOMEN'S HEALTH AND CANCER RIGHTS**

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If you are receiving benefits in connection with a mastectomy and you, in consultation with your attending physician, elect breast reconstruction, we will provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Reconstruction benefits are subject to the same provisions as any other benefit provided under this plan (e.g., deductibles, copay and/or coinsurance).

## **STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

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Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may 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.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

# CUSTOMER SERVICE DIRECTORY

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Please use the following phone numbers and address when you have questions about the Select Network Plan. Our specially trained Boeing Select Network Plan Customer Service Representatives will be able to answer most questions directly or will assist you in getting the help you need.

If you write to us, please send all correspondence to the address listed below:

**Regence BlueShield**  
**Boeing Select Network Plan**  
**Post Office Box 91015**  
**Seattle, WA 98111-9115**

**BOEING SELECT NETWORK PLAN CUSTOMER SERVICE, CLAIM ADMINISTRATION, MEMBER ID CARDS, PHARMACY NETWORK, AND PROVIDER DIRECTORIES** (available without charge):

Toll Free ..... 1-800-422-7713  
FAX..... 1-877-357-3419

**Or visit our Web sites at:**

[www.regence.com/boeing](http://www.regence.com/boeing) or  
[www.myRegence.com](http://www.myRegence.com)

**HOSPITAL PREADMISSION APPROVAL**

Toll Free (in Washington) ..... 1-800-367-2766  
Toll Free (outside Washington) ..... 1-800-423-6884  
Preadmission Approval FAX..... 1-800-453-4341

**CHECKUP** Hotline to report fraud (in Washington)..... 1-800-922-4325

**CHEMICAL DEPENDENCY AND MENTAL HEALTH BENEFITS**

For Chemical Dependency and Mental Health Benefits,  
call ValueOptions at: ..... 1-800-892-1411

**NOTICES**

Any notices under this plan shall be deemed given when deposited in the United States mail, with postage prepaid, addressed to the group representative at his or her last address appearing in the records of the company, or addressed to the Company at the address listed below.

**Regence BlueShield**  
Post Office Box 21267  
Seattle, Washington 98111-3267



1800 Ninth Avenue  
Seattle, Washington 98101-1322

Toll-Free: (800) 422-7713

[www.regence.com/boeing](http://www.regence.com/boeing)