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COMPREHENSIVE MEDICAL PLAN

Summary Plan Description

Effective January 1, 2014

PREMERA BLUE CROSS

Weyerhaeuser

WHO TO CONTACT

PREMERA BLUE CROSS CUSTOMER SERVICE

Please call or write our Customer Service staff for help with the following:

- Questions about the benefits of this plan
- Questions about your claims
- Questions or complaints about care or services you receive

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

Phone Numbers:
Local and toll-free number: 800-995-2420
Local and toll-free TDD number for the hearing impaired: 800-842-5357

Physical Address:
7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

24-Hour NurseLine:
800-995-2420

Online information about your Comprehensive Medical Plan is at your fingertips whenever you need it.

You'll find answers to most of your questions about this plan in this benefit booklet. You also can explore our website at **premera.com/wy** anytime you want to:

- Learn more about how to use this plan
- Locate a health care provider near you
- Get details about the types of expenses you're responsible for and this plan's benefit maximums
- Check the status of your claims

You also can call our Customer Service staff at the numbers listed above. We're happy to answer your questions and appreciate any comments you want to share. In addition, you can get benefit, eligibility and claim information through our Interactive Voice Response system when you call Customer Service.

Weyerhaeuser's Employee Service Center (ESC) for Enrollment and Eligibility:	800-833-0030
SHPS for COBRA Administration:	877-392-3594

Group Name:	Weyerhaeuser Company
Effective Date:	January 1, 2014
Group Number:	1000012
Plan:	Comprehensive Medical plan
Contract Form Number:	2014WH01-SP

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INTRODUCTION

This benefit booklet is for members of the Comprehensive Medical Plan, administered by Premera Blue Cross, an Independent Licensee of the Blue Cross and Blue Shield Association. This booklet describes the benefits of this plan and replaces any other benefit booklet you may have received.

The benefits, limitations, exclusions and other coverage provisions described on the following pages are subject to the terms and conditions of the contract we've issued to Weyerhaeuser Company and its participating U.S. subsidiaries ("Weyerhaeuser"). Weyerhaeuser is the plan sponsor and contracts with Premera Blue Cross to handle day-to-day administration of the plan.

This booklet serves as the summary plan description (SPD). This, together with any group policies constitutes the legal plan document for the medical benefits it describes. The Weyerhaeuser Company Flexible Benefits Plan provides for payment of employee contributions for medical coverage on a pre-tax basis and, as such, governs the pre-tax features of the plan. If there is any conflict between the information in this SPD and the legal plan documents or group insurance policies, the legal plan documents or insurance policies will govern. This is also a part of the complete contract, which is on file at the headquarters of both Weyerhaeuser and Premera Blue Cross.

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see "Definitions"). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

HOW TO USE THIS BOOKLET

We realize that using a medical plan can seem complicated, so we've prepared this booklet to help you understand how to get the most out of your benefits. Please familiarize yourself with the Table of Contents, which lists sections that answer many frequently asked questions.

Every section in this booklet contains important information, but the following sections may be particularly useful to you:

- **WHO TO CONTACT**— our web site address, phone numbers, mailing addresses and other contact information conveniently located inside the front cover
- **HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?** — how using network providers will reduce your out-of-pocket costs
- **WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?** – the types of expenses you must pay for covered services
- **WHAT ARE MY BENEFITS?** — what's covered under this plan. Described within each benefit, you'll find a summary of what you're responsible for paying for covered services
- **WHAT'S NOT COVERED?** — services that are either limited or not covered under this plan
- **WHO IS ELIGIBLE FOR COVERAGE?** – eligibility requirements for this plan
- **HOW DO I FILE A CLAIM?** — step-by-step instructions for claims submissions
- **COMPLAINTS AND APPEALS** — addresses and processes to follow if you want to file a complaint or submit an appeal
- **DEFINITIONS** — many terms have specific meanings under this plan. Example: The terms "you" and "your" refer to members under this plan. The terms "we," "us" and "our" refer to Premera Blue Cross

2014 Benefit Highlights

Comprehensive Medical Plan

Deductibles, coinsurance percentages and copays reflect WHAT YOU PAY.

	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Deductible (deductible applies except as noted)	$300 Individual / $600 Family	
Coinsurance (member's percentage of costs)	15%	35%
Out-of-Pocket Maximum (PCY, includes deductible, coinsurance, emergency room copay and excludes pharmacy copays)	$2,000 Individual / $4,000 Family	Not Applicable
COVERED SERVICES		
PREVENTIVE CARE		
Office Visit (routine physical exams, sports physicals & well-baby exams)	Network services covered in Full; deductible waived	35%
Cancer Screenings[1] (mammograms, colonoscopies, prostate PSA screenings & more)		
Immunizations[1] (flu, HPV/cervical cancer, Hep B, MMR, chicken pox & more)		
General Labs (cholesterol, triglycerides, urinalysis, thyroid & more)		
Other Screenings[1] (bone density study, type 2 diabetes, sexual health & more)		
Routine Vision Exam (One exam PCY)	Covered in Full; deductible waived	
PROFESSIONAL CARE		
Office Visit (includes urgent care visits)	15%	35%
Outpatient Diagnostic Imaging & Laboratory	15%	35%
Inpatient Professional Services	15%	35%
FACILITY CARE		
Inpatient and Outpatient Care	15%	35%
Skilled Nursing Facility (90 days PCY)	15%	35%
EMERGENCY ROOM CARE		
Outpatient Emergency Room Care	$75 Copay; then deductible; then 15% (copay waived if admitted)	
Ambulance Transportation (to nearest treatment facility)	15%	
OTHER SERVICES		
Transplants (donor search & harvest: $75,000; transport & lodging: $7,500)	15%	Not covered
Mental Health	15%; deductible waived	35%; deductible waived
Chemical Dependency	15%; deductible waived	35%; deductible waived
Hospice (Inpatient: 30 days; respite 240 hours; 6-month overall benefit limit)	15%	35%
Home Health Care (130 Visits PCY; Out-of-network shared with in-network limit)	15%	35%
Spinal and Other Manipulations (24 manipulations PCY)	15%	35%
Rehabilitation (Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehabilitation) (Outpatient: 75 Visits PCY; Inpatient: 30 Days PCY)	15%	35%
PHARMACY BENEFITS—Outpatient prescription drugs	**Generic / Preferred Brand / Non-Preferred Brand**	
Retail Pharmacy Up to 30-day supply per prescription	$12 / $30 / $45; copay plus difference if member requests brand when generic is available; deductible waived	
Mail-Service Up to 90-day supply per prescription	$24 / $60 / $87.50; copay plus difference if member requests brand when generic is available; deductible waived	
Specialty Pharmacy Up to 30-day supply per prescription	$12 / $30 / $45; copay plus difference if member requests brand when generic is available; deductible waived	
Out-of-Network Nonparticipating retail and mail pharmacies	Not covered	
Tobacco Cessation	Contact Customer Service for information about tobacco cessation; copay waived	

[1] Age and frequency limitations may apply for certain preventive screenings and services.

Covered in Full = Benefits provided at 100% of allowable charge, not subject to deductible or coinsurance, unless specified.

PCY = Per Calendar Year.

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

This plan's benefits and your out-of-pocket expenses depend on the providers you see. In this section you'll find out how the providers you see can affect this plan's benefits and your costs.

This plan does not require use or selection of a primary care provider, or require referrals for specialty care. Members may self-refer to providers, including obstetricians, gynecologists and pediatricians, to receive care, and may do so without prior authorization.

Network Providers

This plan is a Preferred Provider Plan (PPO). This means that the plan provides you benefits for covered services from providers of your choice. Its benefits are designed to provide lower out-of-pocket expenses when you receive care from network providers. There are some exceptions, which are explained below.

Network providers are:

- Providers in the Heritage network in Washington. For care in Clark County, Washington, you also have access to providers through the BlueCard® Program.
- Providers in Alaska that have signed contracts with Premera Blue Cross Blue Shield of Alaska.
- Providers in the local Blue Cross and/or Blue Shield Licensee's network shown below. (These Licensees are called "Host Blues" in this booklet.) See "BlueCard Program And Other Inter-Plan Arrangements" later in the booklet for more details.
  - California : The local Blue Cross network.
  - Idaho: The local Blue Cross network.
  - Wyoming: The Host Blue's Traditional (Participating) network
  - All Other States: The Host Blue's PPO (Preferred) network

Participating pharmacies are also network providers and are available nationwide.

Network providers provide medical care to members at negotiated fees. These fees are the allowable charges for network providers. When you receive covered services from a network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). Network providers will not charge you more than the allowable charge for covered services. This means that your portion of the charges for covered services will be lower.

A list of network providers is in our Heritage provider directory. You can access the directory at any time on our Web site at **www.premera.com/wy**. You may also ask for a copy of the directory by calling Customer Service. The providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. You can also call the BlueCard provider line to locate a network provider. The number is on the back of your Premera Blue Cross ID card.

Important Note: You're entitled to receive a provider directory automatically, without charge.

Non-Network Providers

Non-network providers are providers that are not in one of the networks shown above. Your bills will be reimbursed at a lower percentage (the out-of-network benefit level).

- Some providers in Washington that are not in the Heritage network do have a contract with us. Even though your bills will be reimbursed at the lower percentage (the non-network benefit level), these providers will not bill you for any amount above the allowable charge for a covered service. The same is true for a provider that is in a different network of the local Host Blue.
- There are also providers who do not have a contract with us, Premera Blue Cross or the local Host Blue at all. These providers have the right to charge you more than the allowable charge for a covered service. You may also be required to submit the claim yourself. See "How Do I File A Claim?" for details.

Amounts in excess of the allowable charge don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Services you receive in a network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are non-network providers. When you receive services from these non-network providers, you may be responsible for amounts over the allowable charge as explained above.

In-Network Benefits For Non-Network Providers

The following covered services and supplies provided by non-network providers will always be covered at the in-network level of benefits:

- Emergency care for a medical emergency. (Please see the "Definitions" section for definitions of these terms.) This plan provides worldwide coverage for emergency care.

  The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard as to whether the health care provider furnishing the

services is a network provider. Emergency care furnished by a non-network provider will be reimbursed on the same basis as a network provider. As explained above, if you see a non-network provider, you may be responsible for amounts that exceed the allowable charge.

- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Heritage provider who doesn't have admitting privileges at a Heritage hospital.
- Covered services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

If a covered service is not available from a network provider, you can receive benefits for services provided by a non-network provider at the in-network benefit level. However, you must request this before you get the care. See "Prior Authorization And Emergency Admission Notification" to find out how to do this.

BENEFIT EXCEPTIONS FOR NON-EMERGENT CARE

A "benefit exception" is our decision to provide in-network benefits for covered services or supplies from a non-network provider.

You, your provider, or the medical facility may ask us for the benefit level exception. If we approve the request, benefits for covered services and supplies will be provided. Payment of your claim will be based on your eligibility and benefits available at the time you get the service or supply. You'll be responsible for amounts applied toward your applicable deductibles, copays, coinsurance, amounts that exceed the benefit maximums, amounts above the allowable charge and charges for non-covered services. If we deny the request, benefits won't be provided at the in-network level.

Please contact Customer Service at the phone numbers shown inside the front cover of this booklet to request benefit level exception.

WHAT TYPES OF COSTS AND EXPENSES AM I RESPONSIBLE FOR PAYING?

This section of your booklet explains how you and Weyerhaeuser share the plan costs. This also defines the types of expenses you must pay for covered services before the benefits of this plan are provided. (These are called "cost-shares" in this booklet.) To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for.

COST OF COVERAGE

You and Weyerhaeuser share in the cost of your medical coverage. To help lower the cost, your contributions generally are deducted from your pay on a pre-tax basis.

If you elect coverage for your domestic partner, the cost of coverage is deducted from your pay on an after-tax basis. The Company's contribution toward domestic partner coverage will, in most cases, be considered imputed income and will be taxable income to you. You are responsible for the income tax on imputed income. This means the Company's contribution for your domestic partner and his or her dependent children will be added to your taxable income, unless you declare that person (and/or their children) to be tax dependents.

You or your dependents may be eligible for financial assistance with the cost of your premiums through the Children's Health Insurance Program (CHIP). See Appendix for additional information.

Your contributions for medical coverage are based on the level of coverage you choose and the number of dependents that you choose to cover. Your contributions are reviewed annually and subject to change, with any adjustments generally effective January 1. You will be notified in advance of changes.

COPAYMENTS

Copayments (hereafter referred to as "copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service.

The copays applicable to the "Medical Services" portion of this plan are located under the "What Are My Benefits?" section.

Copays applicable to retail and mail service pharmacy prescription drug purchases are located under the Prescription Drugs benefit.

Please refer to the Emergency Room Services benefit under the "What Are My Benefits?" section for more details.

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the

calendar year deductible for any covered service or supply won't exceed the "allowable charge" (please see the "Definitions" section in this booklet).

Individual Deductible

An "Individual Deductible" is the amount each member must incur and satisfy before certain benefits of this plan are provided, other than certain benefits that are not subject to the deductible.

Family Deductible

We also keep track of the expenses applied to the individual deductible that are incurred by all enrolled family members combined. When the total equals a set maximum, called the "Family Deductible," we will consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member's individual deductible will count toward the family deductible.

The calendar year deductible amounts applicable to the "Medical Services" portion of this plan are located under the "What Are My Benefits?" section.

What Doesn't Apply To The Calendar Year Deductible?

Amounts that do not accrue toward this plan's calendar year deductible are:

- Charges for behavioral health care (as these services do not require that the deductible be met before they are covered)
- Out-of-pocket expenses paid for routine vision care, if any.
- Charges that are in excess of the allowable amount for out-of-network services.
- Charges for excluded services.
- Copayments, including those stated in the Prescription Drugs benefit.

COINSURANCE

"Coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive. It is the percentage you're responsible for, not including copays and the calendar year deductible, when the plan provides benefits at less than 100% of the allowable charge.

The coinsurance percentage applicable to the "Medical Services" portion of this plan is located under the "What Are My Benefits?" section.

OUT-OF-POCKET MAXIMUM

The "individual out-of-pocket maximum" is the maximum amount, made up of the calendar year deductible, coinsurance and emergency room copay shown under "Medical Services," that each individual could pay each calendar year for covered services and supplies furnished by network providers. There is no out-of-pocket maximum limit for services of providers not in the network.

There are some exceptions. Expenses that do not apply to the out-of-pocket maximum are:

- Charges above the allowable charge
- Services that exceed any benefit maximum or durational limit
- Services not covered by the plan
- Services of non-network providers. However, benefits that always apply network cost-shares, like Emergency Room Services, will apply toward the out-of-pocket maximum.
- Any cost-shares required under the Prescription Drugs benefit.

Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay coinsurance and emergency room copays until your individual out-of-pocket maximum is reached.

Please refer to "What's My Out-of-Pocket Maximum?" in the "What Are My Benefits?" section for the amount of any out-of-pocket maximums you are responsible for.

Once this out-of-pocket maximum has been satisfied, the benefits of this plan will be provided at 100% of allowable charges for the remainder of that calendar year for covered services.

WHAT ARE MY BENEFITS?

This section of your booklet describes the specific benefits available for covered services and supplies. Benefits are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be medically necessary (please see the "Definitions" section in this booklet) medically necessary and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan.
- It must be furnished by a "provider" (please see the "Definitions" section in this booklet) who's performing services within the scope of his or her license or certification.
- It must meet the standards set in our medical and

payment policies. Our policies are used to administer the terms of the plan. Medical policies are generally used to determine if a member has coverage for a specific procedure or service. Payment policies define billing and provider payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA). Our policies are available to you and your provider at **www.premera.com** or by calling Customer Service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions throughout this section and the "What's Not Covered?" section for a complete description of covered services and supplies, limitations and exclusions.

WHAT ARE MY COPAYS?

Emergency Room Copay

For each emergency room visit, you pay $75. Emergency room visits are also subject to any applicable calendar year deductible and coinsurance. The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

WHAT'S MY CALENDAR YEAR DEDUCTIBLE?

Individual Calendar Year Deductible

For each member, this amount is $300 (up to a maximum of $600 for your family if you cover other dependents).

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We do not count allowable charges that apply to your individual calendar year deductible toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to your individual calendar year deductible toward that maximum.

Family Calendar Year Deductible

The maximum calendar year deductible for your family is $600.

WHAT'S MY COINSURANCE?

When you see network providers, your coinsurance is 15% of allowable charges (after deductible), unless otherwise stated.

When you see providers that are not part of our network, your coinsurance is 35% (after deductible) of allowable charges, unless otherwise stated.

WHAT'S MY OUT-OF-POCKET MAXIMUM?

Please Note: There is no out-of-pocket maximum limit for services provided by non-network providers. The calendar year deductible accumulates toward the out-of-pocket maximum.

Individual Out-of-Pocket Maximum

For each member, this amount is $2,000 per calendar year, for care from network providers.

Family Out-of-Pocket Maximum

For each family, this amount is $4,000 per calendar year.

WHAT'S MY ANNUAL PLAN MAXIMUM?

This plan does not have an annual plan maximum.

It's important to note that certain benefits of this plan are subject to separate service-specific benefit maximums.

MEDICAL SERVICES

Ambulance Services

The following services (unless noted) are subject to your calendar year deductible and coinsurance.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the member that requires transportation.

Ambulatory Surgical Center Services

The following services are subject to your calendar year deductible and coinsurance.

Benefits are provided for services and supplies furnished by an ambulatory surgical center.

Blood Products and Services

Benefits are provided for blood and blood derivatives, subject to your calendar year deductible and coinsurance.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services. The Chemical Dependency Treatment benefit does not have its own benefit maximum.

Note: Weyerhaeuser also provides an Employee Assistance Program (EAP) that provides a variety of services for employees and/or dependents/household members who are

experiencing life issues. If you require Chemical Dependency Treatment, you may have access to additional services through the EAP that are available to use prior to using your medical coverage. Please see “Employee Assistance Program” benefit booklet. You may request a copy of this booklet by contacting the Employee Service Center at 800-833-0030.

Benefits are subject to your coinsurance; the calendar year deductible is waived for inpatient or outpatient treatment. To find the amounts you are responsible for, please see the first few subsections of this "What Are My Benefits?" section.

Covered services include services provided by a state-approved treatment program or other licensed or certified provider.

The current edition of the **Patient Placement Criteria for the Treatment of Substance Related Disorders** as published by the American Society of Addiction Medicine is used to determine if chemical dependency treatment is medically necessary.

Please Note: Medically necessary detoxification is covered under the Emergency Room Services and Hospital Inpatient Care benefits.

The Chemical Dependency Treatment benefit doesn’t cover:

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, unless they are medically necessary
- Family and marital counseling, and family and marital psychotherapy as distinct from counseling, except when medically necessary to treat the diagnosed substance use disorder or disorders of a member.
- Halfway houses, quarterway houses, recovery houses, and other sober living residences
- Outward bound, wilderness, camping or tall ship programs or activities
- Residential treatment programs or facilities that are not units of legally-operated hospitals, or that are not state licensed or approved facilities for the provisions of residential chemical dependency treatment
- Residential detoxification

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs mean medically necessary care that is normally covered under this plan outside the clinical trial. Benefits are based on the type of service you get. For example, benefits for an office visit are covered under the Professional Visits And Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a trial that is funded and supported by the National Institutes of Health, the Center for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs.

We encourage you or your provider to call customer service before you enroll in a clinical trial. We can help you verify that the clinical trial is a qualified clinical trial. You may also be assigned a nurse case manager to work with you and your provider. See "Case Management" for details.

Contraceptive Management and Sterilization Services

Benefits for contraceptive management and sterilization aren't subject to any cost-shares (see "Definitions") when you use a network provider.

Please Note: If the contraceptive management or sterilization services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you’ll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

This benefit covers the following services and supplies received from a health care provider:

- Office visits and consultations related to contraception
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility charges will be subject to your cost-shares under the applicable facility benefit and are not covered by this benefit.

Prescription Contraceptives Dispensed By A Pharmacy

Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the Prescription Drugs benefit. Your normal cost-share is waived for these devices and for generic and single-source brand name birth control drugs when you get them from a participating

pharmacy. Examples of covered devices are diaphragms and cervical caps.

Over-the-counter female contraceptives that are prescribed by your healthcare provider and purchased through a licensed pharmacy are also covered. No cost-share is required when you get them through a participating pharmacy. **Please have your prescription ready for the pharmacist**

The Contraceptive Management and Sterilization benefit doesn't cover:

- Over-the-counter male contraceptive drugs, supplies or devices
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Hysterectomy. (Covered on the same basis as other surgeries. See the Surgical Services benefit.)
- Sterilization reversal

Testing, Diagnosis and Treatment of Infertility

Benefits are provided for infertility testing, diagnosis and treatment, including related imaging and laboratory services, up to a lifetime maximum benefit of $5,000 per member.

Benefits for the following infertility services are subject to your calendar year deductible and coinsurance:

- Inpatient Facility Service

  Note: Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.
- Inpatient Professional Services
- Outpatient Surgical Facility Services
- Testing and Surgical Procedures
- Outpatient Professional Visits
- Other Professional Services

When two eligible members are involved in the treatment, the costs of the services are accumulated to each member's benefit maximum as follows:

- Any eligible service, procedures, test, drug or supply used to evaluate or treat one member is assigned to that member's benefit maximum.
- Any eligible service, procedure, test, drug or supply performed that cannot be assigned specifically to either of the participants using the criteria described above, will be assigned to the benefit maximum of the member whose name appears on the claim submitted for those services.

Infertility drugs, including fertility enhancement medications, dispensed by a licensed pharmacy are covered up to a lifetime maximum of $1,000 per member. Please see the Prescription Drugs benefit. Your copayment for these drugs do not count toward your out-of-pocket maximum

Services that are not eligible for reimbursement include, but are not limited to:

- Fees paid to donors for their participation in any service
- Assisted fertility services, procedures, drugs or supplies determined to be experimental or investigative
- Cryopreservation beyond an initial 12 month period
- Reversal of tubal ligation or vasectomy

Dental Services

This benefit will only be provided for the dental services listed below.

Care For Injuries

Professional Visits and Treatment
Benefits for these services are subject to your calendar year deductible and coinsurance when provided by a network provider, and applies to dentist visits to examine the damage done by a dental injury and recommend treatment.

Please Note: If the above services and supplies are furnished by a non-network provider or medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

When services are related to an injury, benefits are provided for the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth do not have:
- Extensive restoration, veneers, crowns or splints
- Periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury

Please Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We

must receive extension requests within 12 months of the injury date.

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and coinsurance. **Note:** Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.

Ambulatory Surgical Center Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

Anesthesiologist Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

General anesthesia and related facility services for dental procedures are covered when medically necessary for 1 of 2 reasons:

- The member is under the age of 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center

Please Note: This benefit will not cover the dentist's services unless the services are to treat a dental injury and meet the requirements described above.

Diagnostic Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

Benefits are provided for diagnostic services (except as specified under the "Preventive Screening Services" section), including administration and interpretation. Some examples of what is covered are:

- Diagnostic imaging and scans (including x-rays)
- Laboratory services
- Pathology tests

Please Note:

- Diagnostic surgeries, including biopsies, and scope insertion procedures, such as an endoscopy, can only be covered under the Surgical Services benefit except as specified under the "Preventive Screening Services" section.
- Allergy testing is covered only under the Professional Visits And Services benefit.
- When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit.
- When outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.

For mammography services, please see the Mammography Services benefit.

For diagnostic services related to the testing, diagnosis or treatment of infertility, please see the Testing, Diagnosis, and Treatment of Infertility and Procedures benefit.

Emergency Room Services

You pay a $75 copay per visit to the emergency room. These services are also subject to your in-network calendar year deductible and coinsurance.

Please Note: The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

This benefit is provided for emergency room services, including related services and supplies, such as diagnostic imaging (including x-ray) and laboratory services, surgical dressings and drugs, furnished by and used while at the hospital.

Health Management

These services are provided at 100% of allowable charges, and are not subject to a calendar year maximum.

Benefits are only provided when the following services are furnished by a network or approved provider or facility. To find out whether the provider you have chosen is approved, please contact our Customer Service department.

Health Education

Benefits are provided for outpatient health education services to manage a covered condition, illness or injury. Examples of covered health education services are asthma education, pain management, childbirth and newborn parenting training and lactation.

Diabetes Health Education

Benefits are provided for outpatient health education and training services to manage the condition of diabetes. Benefits for these services aren't subject to a calendar year benefit limit.

Nicotine Dependency Programs

Benefits are provided for nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a

reimbursement form. When we receive these items, the plan will provide benefits as stated above in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

Prescription drugs for the treatment of nicotine dependency are also covered under this plan. Please see the Prescription Drugs benefit.

Home Health and Hospice Care

The following services are subject to your calendar year deductible and coinsurance.

To be covered, home health and hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (M.D. or D.O.). In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without home health or hospice services.

Benefits are provided, up to the maximums indicated below, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state in which it operates.

Covered employees of a home health agency and hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work. Also included in this benefit are medical equipment and supplies provided as part of home health care.

Home Health Care

This benefit provides up to 130 intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit. Home health care provided as an alternative to inpatient hospitalization is not subject to this limit.

An intermittent visit is one that uses the reasonable amount of time required to perform a specific skilled medical service.

Hospice Care

Benefits for a terminally ill member shall not exceed 6 months of covered hospice care. Benefits may be provided for an additional 6 months of care in cases where the member is facing imminent death or is entering remission. The initial 6-month period starts on the first day of covered hospice care. Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees listed under the Home Health and Hospice Care benefit. These services do not count toward the 130 intermittent home visit limit shown above under Home Health Care. An intermittent visit is one that uses the reasonable amount of time required to perform a specific skilled medical service.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member
- **Inpatient hospice care** up to a maximum of 30 days for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician. Inpatient hospice care is subject to your calendar year deductible and coinsurance. **Note:** Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.

Insulin and Other Home Health and Hospice Care Provider Prescribed Drugs

Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice during a period of covered home health or hospice care. The drugs must be prescribed in the written plan of care and are subject to your calendar year deductible and coinsurance.

This benefit doesn't cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services.
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

Hospital Inpatient Care

The following services are subject to your calendar year deductible and coinsurance. **Note:** Please have your provider notify Customer Service before

inpatient admission to a facility or within 48 hours of emergency admission to a facility.

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives and their administration

For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

For inpatient hospital chemical dependency care, please refer to the Behavioral Health Care section in this booklet.

This benefit doesn't cover:

- Hospital admissions, unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition

Hospital Outpatient Care

Outpatient Surgery Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

Other Outpatient Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

This benefit is provided for operating, procedure, and recovery rooms; plus services and supplies, such as diagnostic imaging (including x-ray) and laboratory services, surgical dressings and drugs, furnished by and used while at the hospital.

Infusion Therapy

The following services are subject to your calendar year deductible and coinsurance.

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

This benefit does not cover over-the counter drugs, solutions and nutritional supplements.

Mammography Services

- **Routine Screening**

  Benefits for routine mammography services are covered in full (you pay no coinsurance and your calendar year deductible is waived).

- **Diagnostic Mammography**

  Benefits for diagnostic mammography services are subject to your calendar year deductible and coinsurance.

Please Note: If you see a provider other than a network provider, benefits for routine mammography are subject to your deductible and coinsurance. For an explanation of the amount you will pay for services and supplies from providers who are not in the provider network, please see the "What Are My Benefits?" section of this booklet.

Benefits are provided for routine and diagnostic mammography recommended by your physician, advanced registered nurse practitioner or physician's assistant.

Mastectomy and Breast Reconstruction Services

Benefits for these services are subject to your calendar year deductible and coinsurance:

- Inpatient Facility Services

  Note: Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.
- Inpatient Professional and Surgical Services
- Outpatient Surgical Facility Services
- Outpatient Professional Visits
- Other Outpatient Professional Services

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Treatment of physical complications of all stages of mastectomy, including lymphedemas
- Prostheses

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

Medical Equipment and Supplies

The following services are subject to your calendar year deductible and coinsurance.

You don't have to pay these cost-shares when you purchase a breast pump from a network provider as described later in this benefit.

Covered medical equipment, prosthetics and supplies (including sales tax for covered items) include:

Medical and Respiratory Equipment

Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. The plan may also provide benefits for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, the plan will provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical Supplies, Orthotics (Other Than Foot Orthotics), and Orthopedic Appliances

Covered services include, but are not limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

Benefits are also provided for vision hardware for the following medical conditions of the eye; corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, please see the Prescription Drugs benefit.

Please Note: This benefit does not include medical equipment or supplies provided as part of home health care. See the Home and Hospice Care benefit for coverage information.

Prosthetics

Benefits for external prosthetic devices (including fitting expenses) as stated below, are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

This benefit also provides for the first intraocular lens prescribed to replace the lens of the eye.

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

Foot Orthotics and Therapeutic Shoes

Only when prescribed for the condition of diabetes, or for corrective purposes, benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses.

Medical Vision Hardware

Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

Breast Pumps

This benefit covers the purchase of a standard electric breast pumps. Rental of hospital grade breast pumps is also covered when medically necessary. Purchase of hospital-grade pumps is not covered.

For further information, please see the Preventive Care benefit.

This benefit doesn't cover:

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Eyeglasses or contact lenses for conditions not

listed as a covered medical condition, including routine eye care

- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.

Mental Health Care

Benefits for mental health services, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided as stated below. This coverage does not have its own benefit maximum.

Note: Weyerhaeuser also provides an Employee Assistance Program (EAP) that provides a variety of services for employees and/or dependents/household members who are experiencing life issues. If you require Chemical Dependency Treatment, you may have access to additional services through the EAP that are available to use prior to using your medical coverage. Please see “Employee Assistance Program” benefit booklet. You may request a copy of this booklet by contacting the Employee Service Center at 800-833-0030.

Benefits are subject to your coinsurance; the ~~same~~ calendar year deductible is waived for inpatient or outpatient treatment. To find the amounts you are responsible for, please see the first few subsections of this "What Are My Benefits?" section.

Covered mental health services are inpatient care, partial hospitalization and outpatient therapeutic visits to manage or lessen the effects of a psychiatric condition. Also covered under this benefit are outpatient biofeedback services for generalized anxiety disorder when provided by a qualified provider.

"Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Current Procedural Terminology** manual, published by the American Medical Association.

Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice.

Covered services must be furnished by one of the following types of providers:

- Hospital
- State-licensed community mental health agency
- Licensed physician (M.D. or D.O.)
- Licensed psychologist (Ph.D.)
- A state hospital operated and maintained by the state in which it operates for the care of the mentally ill
- Any other provider listed under the definition of "provider" (please see the "Definitions" section in this booklet) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license.

For psychological and neuropsychological testing and evaluation benefit information, please see the Psychological and Neuropsychological Testing benefit.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

The Mental Health Care benefit doesn’t cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed mental disorder or disorders of a member
- Mental health residential treatment.
- Therapeutic or group homes; foster homes, nursing homes boarding homes or schools, military academies, and child welfare facilities
- Outward bound, wilderness, camping or tall ship programs or activities
- Telephonic services except for crisis /emergency evaluations, or when the member is temporarily confined to bed for medical reasons; telehealth services that do not utilize real-time video or audio services.
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluation, forensic evaluations, vocational, educational or academic placement evaluations.

Neuropsychological Testing

The following services are subject to your calendar year deductible and coinsurance.

Benefits are provided up to a maximum benefit of 12 hours per member each calendar year for all services combined except for mental health. Neuropsychological testing for mental health is

unlimited. Covered services include testing related to rehabilitation and neurodevelopmental therapy, and evaluations, including interpretation, necessary to prescribe an appropriate treatment plan. This includes later re-evaluations to make sure the treatment is achieving the desired medical results.

Newborn Care

You can enroll your newborn in the plan by contacting Weyerhaeuser's Employee Service Center at 800-833-0030 within 31 days from the date of birth. Coverage will be retroactive to the date of birth.

Plan benefits will apply, subject to the child's own applicable copay, calendar year deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

Benefits for these services are subject to your calendar year deductible and coinsurance.

Note: Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.

Please Note: If the newborn is admitted to a non-network medical facility, benefits for inpatient facility services are subject to your coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this booklet.

Hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice is covered. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury.

Group medical plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Professional Care

- Inpatient newborn care, including newborn exams
- Follow-up care, including newborn exams, consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision

This benefit doesn't cover immunizations and outpatient well-baby exams. See the Preventive Care benefit for coverage of immunizations and outpatient well-baby care.

Inpatient Professional Care

Benefits for these services are subject to your calendar year deductible and coinsurance.

Outpatient Professional Visits

Benefits for these services are subject to your calendar year deductible and coinsurance.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

Nutritional Therapy

Benefits for the following services aren't subject to your calendar year deductible or coinsurance when you use a network provider.

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. Nutritional therapy for conditions other than diabetes is limited to 4 visits per member each calendar year. Nutritional therapy for the condition of diabetes isn't subject to a calendar year benefit limit.

Obstetrical Care

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for all female members. Preventive diagnostic services that meet the guidelines for preventive care are covered for all eligible members as stated in the Preventive Care benefit.

Facility Care

Inpatient Hospital Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

Note: Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.

This benefit covers inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

Group health plans and health insurance issuers generally may not, under federal law, restrict

benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Plan benefits are also provided for medically necessary supplies related to home births.

Professional Care

Benefits for the following obstetrical care services are subject to your calendar year deductible and coinsurance:

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
- Delivery, including cesarean section, in a medical facility, or delivery in the home
- Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. Please see the Surgical Services benefit for details on surgery coverage.

Orthognathic Surgery (Jaw Augmentation Or Reduction)

Benefits for the following services are subject to your calendar year deductible and coinsurance:

- Inpatient Facility Services **Note:** Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.
- Inpatient Professional Services
- Outpatient Surgical Facility Services
- Outpatient Professional Visits
- Other Professional Services

When medical necessity criteria are met, benefits for upper and/or lower jaw augmentation or reduction (orthognathic and/or maxillofacial) surgery are provided. Orthognathic surgery isn't subject to a calendar year benefit limit.

Phenylketonuria (PKU) Dietary Formula

Benefits for PKU dietary formula are subject to your calendar year deductible and coinsurance.

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU).

Preventive Care

For Network Providers

Benefits are covered in full (you pay no coinsurance and your calendar year deductible is waived) for the following routine and preventive services performed on an outpatient basis, which are not subject to a calendar year benefit limit.

For Non-Network Providers

Benefits are subject to your calendar year deductible and coinsurance.

Routine or Preventive Exams and Preventive Screening Services

For outpatient diagnostic services (not routine or preventive, including x-ray and laboratory) please see the Diagnostic Services benefit.

Preventive services are defined to include:

- Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Task Force (USPSTF). Also included are additional preventive care and screenings for women not described above in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

A full list of these preventive services is available on our website or by calling Customer Service. The list includes information about how often the services should be provided and who should receive the recommended services.

Covered preventive services include:

Preventive Care	Services Covered in Full
Office Visit	• Routine physical exam • Well-baby exams • Physical exams related to school, sports and employment

Cancer Screenings	• Mammograms • Pap smear • Ovarian CA-125 • Colonoscopies, Sigmoidoscopies & Barium enema (age 50 and over) • Fecal Occult Blood Test • Prostate specific antigen
Immunizations	• Hepatitis B (Hep B) • Diphtheria, Tetanus, Pertussis (DTaP) • H. influenza type B (Hib) • Polio (IPV) • Pneumonia (PCV or PPV) • Measles, Mumps, Rubella (MMR) • Varicella (Chicken Pox) • Influenza (Flu) • Hepatitis A • Quadrivalent HPV
General Labs	• Complete blood count • Lipid panel - – Cholesterol – Lipoprotein – Triglycerides • General Chemistry Panel - – Basic metabolic panel – Comprehensive – Metabolic panel – Renal function panel – Electrolyte panel • Urinalysis • Thyroid • General health panel
Other Screenings	• Bone density (DEXA) (age 60 and over) • Type 2 Diabetes-glucose testing (age 45 and older) • Abdominal aortic aneurysm (age 65 and over, limit one per lifetime) • Sexual Health Screenings - – Chlamydia – Gonorrhea – Hepatitis – HIV – Syphilis

Please Note: If the above services are received by outside of the age limits listed, benefits are subject to your calendar year deductible and coinsurance.

For other outpatient diagnostic services (including x-ray and laboratory) please see the Diagnostic Services benefit.

Immunizations

Benefits for immunizations are covered in full (you pay no coinsurance and your calendar year deductible is waived). Immunization benefits are not subject to a calendar benefit limit.

When you use a non-network provider, benefits are subject to your calendar year deductible and coinsurance.

Services that are related to a specific illness, injury or definitive set of symptoms are covered under the non-preventive medical benefits of this plan.

Women's Preventive Care

Benefits for women's preventive care, as defined by regulation for women's health, aren't subject to any deductible or coinsurance when you use a network provider.

Examples of covered women's preventive care services include but are not limited to, contraceptive counseling, breast feeding counseling, maternity diagnostic screening, screening for gestational diabetes, and counseling about sexually transmitted infections. A full list of preventive services is available on our web site or by calling Customer Service.

Please see the Medical Equipment And Supplies benefit for details on breast pump coverage. Please also see the Contraceptive Management And Sterilization, Diagnostic Services, Health Management, and Obstetrical Care benefits for further detail.

Fall Prevention

Professional services to prevent falling for members who are 65 or older and have a history of falling or mobility issues.

This benefit doesn't cover:

- Charges that don't meet the federal guidelines for preventive services described at the start of this benefit. This includes services or items provided more often than as stated in the guidelines.
- Charges for preventive medical services that exceed what's covered under this benefit
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit
- Routine or other dental care
- Routine vision and hearing exams
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations

- Facility charges. When you get preventive care at a clinic or physician's office that is based in a hospital, you must pay hospital cost shares when there are any extra facility charges. See the Hospital Outpatient Care benefit for those costs.

Professional Visits and Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home.

Benefits for the following services are subject to your calendar year deductible and coinsurance:

- Outpatient Professional Exams and Visits
- Other Professional Services

Benefits are also provided for the following:

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback services for any covered medical diagnosis or treatment plan
- Diabetic foot care
- Repair of a dependent child's congenital anomaly
- Consultations and treatment for nicotine dependency

Therapeutic Injections And Allergy Tests

Benefits for these services are subject to your calendar year deductible and coinsurance.

Benefits are available for the following:

- Therapeutic injections, including allergy injections
- Allergy testing

For surgical procedures performed in a provider's office, surgical suite or other facility benefit information, please see the Surgical Services benefit.

For professional diagnostic services benefit information, please see the Diagnostic Services benefit.

For home health or hospice care benefit information, please see the Home Health and Hospice Care benefit.

For benefit information on contraceptive injections or implantable contraceptives, please see the Contraceptive Management, Sterilization, and Infertility Services benefit.

For diagnosis and treatment of temporomandibular joint (TMJ) disorders benefit information, please see the Temporomandibular Joint (TMJ) Disorders benefit.

Rehabilitation Therapy, Neurodevelopmental Therapy and Chronic Pain Care

Rehabilitation and Neurodevelopmental Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies; 3) to improve function, or maintain function where significant physical deterioration would occur without the therapy.

Inpatient Care Benefits for inpatient facility and professional care are available up to 30 days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

Inpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance. **Note:** Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

Outpatient Care Benefits for outpatient care are subject to all of the following provisions:

- You must not be confined in a hospital or other medical facility
- Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, physical, occupational, speech, massage therapist, or naturopath

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 75 visits per member each calendar year.

Outpatient Facility Care

Benefits for these services are subject to your calendar year deductible and coinsurance.

Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and coinsurance.

A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Chronic Pain Care

These services must be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits. All benefit maximums apply. However, inpatient services for chronic pain care are not subject to the 24-months under the Rehabilitation Therapy Benefit from onset limit mentioned above.

For neuropsychological testing and evaluation benefit information, please see the Neuropsychological Testing benefit.

This benefit doesn't cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary (except Chronic Pain Care)

Skilled Nursing Facility Services

The following services are subject to your calendar year deductible and coinsurance.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 90 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility.

This benefit doesn't cover:

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

Spinal and Other Manipulations

The following services are subject to your calendar year deductible and coinsurance.

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition.

Non-manipulation services (including diagnostic imaging) are covered as any other medical service.

Available benefits for covered massage and physical therapy services are provided under the Rehabilitation Therapy and Chronic Pain Care benefits.

Benefits are limited to 24 manipulations per member per calendar year.

Surgical Services

The following services are subject to your calendar year deductible and coinsurance.

This benefit covers surgical services (including injections) that are not named as covered under other benefits, when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office. Also covered under this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts and the transfusion of blood or blood derivatives. Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services as described in the Preventive Care benefit.

Anesthesia that is delivered by an anesthesiologist for colonoscopies and sigmoidoscopies is not covered unless it meets medical criteria.

For organ, bone marrow or stem cell transplant procedure benefit information, please see the Transplants benefit.

Temporomandibular Joint (TMJ) Disorders

Benefits for the following services are subject to your calendar year deductible and coinsurance:

- Inpatient Facility Services

  Note: Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.
- Inpatient Professional and Surgical Services
- Outpatient Surgical Facility Services
- Outpatient Professional Visits
- Other Outpatient Professional Services

Benefits for medical and dental services and supplies for the treatment of temporomandibular

joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. This benefit includes coverage for inpatient and outpatient facility and professional care, including professional visits.

Medical and dental services and supplies are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- 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
- Recognized as effective, according to the professional standards of good medical or dental practice
- Not experimental or investigational, as determined by us according to the criteria stated under "Definitions," or primarily for cosmetic purposes

Please Note: Excluded from this benefit is non-surgical TMJ treatment such as occlusal devices, splints and guards. Please refer to your Dental plan for more benefit information on TMJ.

Tobacco Cessation Program

Benefits are covered in full (you pay no coinsurance and your calendar year deductible is waived) for tobacco cessation programs. You pay for the cost of the program and send us proof of payment along with a subscriber claim form. Please contact our Customer Service department (see the "Who To Contact" section inside the front cover of this booklet) for a subscriber claim form.

Prescription drugs for the treatment of nicotine dependency are covered under your prescription drug benefit. Prescription drugs associated with nicotine dependency are only covered if you also enroll in the Quit For Life™ Program. Call 866-784-8454 for more information. Once you enroll, authorization to receive coverage is released to your pharmacy. Some prescription drugs associated with nicotine dependency are subject to plan limits.

Transplants

This benefit covers medical services only if provided by network providers or approved transplant centers. A benefit advisory is recommended. (Please see the Care Management section and the "Definitions" Section for information on the Benefit Advisory Process.) Please see the transplant benefit requirements later in this benefit section for more information about approved transplant centers.

Benefits are provided for the following services by a network provider or an approved transplant provider, and are subject to your calendar year deductible and coinsurance:

- Inpatient Facility Services

  Note: Please have your provider notify Customer Service before inpatient admission to a facility or within 48 hours of emergency admission to a facility.
- Inpatient Professional and Surgical Services
- Outpatient Surgical Facility Services
- Other Outpatient Professional Services

Covered Transplants

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Please see the "Definitions" section in this booklet for the definition of "experimental/investigational services.") We reserve the right to base coverage on all of the following:

- Organ transplants and bone marrow/stem cell reinfusion procedures must meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

Please Note: For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (please see the Surgical Services benefit).

- Your medical condition must meet our written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An approved transplant center is a hospital or other provider that's developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) We have agreements with approved transplant centers in

Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

Of course, if none of our centers or the approved transplant centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

Recipient Costs

This benefit covers transplant and reinfusion-related expenses, including the preparation regimen for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs

Procurement expenses are limited to $75,000 per transplant. All covered donor costs accrue to the $75,000 maximum, no matter when the donor receives them. Covered services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation and Lodging Expenses

The transport and lodging benefits are subject to your in-network calendar year deductible, but aren't subject to your in-network coinsurance. Benefits are provided up to the benefit limit of $7,500 per transplant.

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

- The transplant recipient must reside more than 50 miles from the approved transplant center unless medically necessary treatment protocols require the member to remain closer to the transplant center
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided up to a maximum of $125 per day
- When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided up to a maximum of $80 per day
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companions are limited to $7,500 per transplant

This benefit doesn't cover:

- Airfare
- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they are not experimental/ investigational services" (please see the "Definitions" section in this booklet)
- Personal care items
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed
- Take-home prescription drugs dispensed by a licensed pharmacy. See the "What Are My Prescription Drug Benefits?" section for benefit information

VISION BENEFIT

Vision Exams

Benefits are covered in full (you pay no coinsurance and your calendar year deductible is waived).

Vision benefits are based on the "allowable charge" (please see the "Definitions" section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit are not covered under other benefits of this plan.

Plan benefits for routine vision exams, as well as any related out-of-pocket expenses, do not apply toward the calendar year out-of-pocket maximum.

This benefit provides for one routine vision exam per member each calendar year. Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

Please Note: For vision exams and testing related to medical conditions of the eye, please see the Professional Visits and Services benefit.

Vision Hardware

Benefits for the vision hardware supplies listed below are provided when they meet all of these requirements:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be named in this benefit as covered
- They must not be excluded from coverage under this plan

Benefits for the following vision hardware and related services are covered in full (you pay no coinsurance and your calendar year deductible is waived), up to the following benefit maximums:

Dependent Children Ages 0-18:

- One pair of eyeglass lenses per calendar year and one pair of frames every (2) two consecutive calendar years.
  OR
- One year supply of contact lenses

Members Ages 19 and Older: $200 per member every two (2) consecutive calendar years

What's Covered:

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Vision hardware benefits are based on the "allowable charge" (please see the "Definitions" section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit are not covered under other benefits of this plan.

Please Note: Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan do not apply to vision hardware benefits.

The Vision Hardware benefit doesn't cover:

- Services or supplies that are not named above as covered, or that are covered under other provisions of this plan. Please see the Medical Equipment and Supplies benefit for hardware coverage for certain conditions of the eye.
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
- You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
- You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

HOW DO I FILE A VISION CLAIM?

Vision Hardware Claims

You must pay for services upfront, then complete a Subscriber Claim Form and attach an itemized bill. Any applicable payment will be sent to you. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service or going to **www.premera.com/wy.** If you need to submit a claim to us, follow the simple steps located in the "How Do I File A Claim?" section of this book.

Vision Exam Claims for a Non-Preferred Provider

You must pay for services upfront, then complete a Subscriber Claim Form and attach an itemized bill. Any applicable payment will be sent to you. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service or going to **www.premera.com/wy.** If you need to submit a claim to us, follow the simple steps located in the "How Do I File A Claim?" section of this book.

Vision Exam Claims for a Preferred Provider

Most preferred providers will submit their bills to their local Blue Cross / Blue Shield plan and will be subject to the terms of their contract with the local Blue Cross / Blue Shield; or you may opt to submit to us directly. However, if you need to submit a claim to us, follow the simple steps located in the "How Do I File A Claim?" section of this book.

Please submit vision claims to:
Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

PRESCRIPTION DRUGS

The plan's prescription drug benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered under this benefit are self-administered injectable drugs and supplies. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of-pocket expense exceed the cost of the drug or supply.

Prescription drugs may be obtained under the plan through retail, mail order, or specialty pharmacy. These methods are covered in more detail in the next few sections.

Each member must pay a copay for each separate new prescription or refill. A "copay" is defined as a fixed up-front dollar amount that you're required to pay the pharmacy for each prescription drug purchase. The plan's prescription drug benefit copay arrangement is organized into three tiers, as described in the next sections.

Retail Pharmacy

Generic Drugs.....$12 copay

Preferred List Brand Name Drugs.....$30 copay

Non-Preferred List Brand Name Drugs.....$45 copay

Dispensing Limit

Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of up to a 90-day supply is allowed when the drug maker's packaging doesn't allow for a lesser amount. If any prescriptions require a copay, you would be charged an additional copay for each 30-day supply, or the cost of the drug if that cost doesn't exceed the cost of the copay.

Mail Service Pharmacy

Generic Drugs.....$24 copay
Preferred List Brand Name Drugs.....$60 copay
Non-Preferred List Brand Name Drugs.$87.50 copay

Dispensing Limit

Benefits are provided up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Specialty drugs are limited to a 30-day supply at the retail copay.

Specialty Pharmacy

Generic Drugs.....$12 copay

Preferred List Brand Name Drugs .....$30 copay

Non-Preferred List Brand Name Drugs.....$45 copay

Dispensing Limit

Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

Oral Chemotherapy Medication

This benefit covers self-administered oral medication that can be used to kill cancerous cells or slow their growth when the medication is dispensed by a pharmacy. When medically necessary for all covered health conditions, these drugs are subject to your copay.

Injectable Supplies

When hypodermic needles and syringes are purchased along with the related injectable prescription medication, only the copay for the injectable prescription medication will apply.

When hypodermic needles and syringes are purchased separately from the related injectable prescription medication, the preferred list brand name drug copay will apply for each item purchased, if you have a written prescription from your provider for each item.

Depending on preferred or non-preferred classification, the appropriate Brand Name Drug copay will apply to purchases for alcohol swabs, test strips, testing agents and lancets. A separate copay will apply to each item purchased.

Retail Pharmacy Benefit

- **Participating Retail Pharmacies**

Your benefits only cover prescription drugs dispensed from a participating pharmacy. After you've paid any required copay, we will pay the participating pharmacy directly.

To receive the highest level of benefits, be sure to present your identification card to the pharmacist for all prescription drug purchases.

If you do not show your ID card, you'll have to pay the full cost of the prescription and submit the claim yourself. You will be reimbursed at a lower allowable charge for the prescription, minus your copay.

To find a participating pharmacy, use the Provider Directory or call the toll-free Pharmacy Locator line located on the back of your ID card. If you need a list of participating pharmacies, please call us (see the "Who To Contact" section inside the front cover of this booklet).

- **Non-Participating Pharmacies**

Your benefits do not cover prescription drugs dispensed from a non-participating pharmacy.

Mail Service Pharmacy Benefit

If you take a long-term medication(s), using the mail service through Express Scripts Home Delivery can save you time and money. This service lets you receive prescriptions up to a 90-day supply at a lower out-of-pocket cost than what you would pay for an equal supply at a retail pharmacy. Specialty drugs are limited to 30-day supply at the retail copay.

After you've paid any required copay, we will pay the mail service pharmacy directly. This benefit is limited to prescriptions filled by Express Scripts Home Delivery.

It can take up to two weeks for delivery, so be sure to have enough medication on hand. For new medicines, avoid delay in starting your medicine by asking your provider to write two separate prescriptions—one for 30 days that you can fill at a local pharmacy right away, and one for 90 days that you can mail in to Express Scripts Home Delivery. If refills are allowed, be sure your provider indicates that on the prescription.

For more information about the mail service pharmacy program, or to obtain order forms, visit **www.premera.com/wy/pharmacy** or call us (see the "Who to Contact" section inside the front cover of this booklet). You can also contact Express Scripts Home Delivery directly at 800-391-9701.

Specialty Pharmacy Benefit

If you take a specialty drug, our Preferred Specialty Pharmacy vendor(s) can provide you with additional benefits and clinical support. Specialty Pharmacies specialize in the delivery and clinical management of "specialty or biotech" drugs. These specialty drugs are high cost drugs, often self-injected and used to treat complex or rare conditions including Rheumatoid Arthritis, Multiple Sclerosis and Hepatitis C. Specialty drugs may also require special handling or delivery.

These medications can only be dispensed for up to a 30-day supply. Specialty Pharmacies provide additional benefits and clinical support. They include:

- Care Management and Coordination of Care
- Medication Adherence and Compliance Monitoring
- Educational Materials and Product Information
- Clinical Assistance from Nurses and Pharmacists
- Coordination of Medication Delivery Time and Location

Specialty drugs can only be dispensed by our Preferred Specialty Pharmacy vendor(s). You will have access to the additional clinical support mentioned above, without any additional cost. Regardless of what pharmacy you use, specialty drugs will be limited to a 30-day supply at the retail copay.

For more information about specialty drugs or for a complete list of specialty drugs covered under this benefit, please go to **www.premera.com/wy/pharmacy** or call customer service.

Please Note: Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan do not apply to this benefit. Copays required under this benefit do not apply to other benefits of this plan.

What's Covered

This benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility. For more information or information about specific coverage, please call us (see "Who to Contact" section inside the front cover of this booklet).

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider)
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Prescription drugs for the treatment of nicotine dependency. Prescription drugs for this purpose are only covered if you also enroll in the Quit For Life™ Program. Call 866-784-8454 for more information. Some prescription drugs associated with nicotine dependency are subject to plan limits.
- Prescription drugs to treat infertility, including fertility enhancement medications up to a $1,000 lifetime maximum per enrollee
- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps, estrogen rings)
- Birth control drugs and devices that require a prescription. Your normal cost-share is waived for these devices and for generic and single-source brand name birth control drugs when you get them from a participating pharmacy.

For benefit information concerning therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit), please see the Medical Equipment and Supplies benefit.

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the Preventive Care benefit.

Exclusions

This benefit excludes the following items. For more information or information about specific coverage, please call us (see "Who to Contact" section inside the front cover of this booklet).

- Drugs not approved by the Federal Drug Administration (FDA). Please see the "Definitions Section under Prescription Drug."
- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but are not limited to non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Non-prescription male contraceptive methods, such as condoms, even if prescribed
- Therapeutic devices, appliances and durable medical equipment, including blood glucose monitors
- Ostomy supplies
- Medication used to enhance athletic performance
- Drugs that may be covered under local, state or federal programs including Worker's Compensation
- Prescription contraceptive implants (e.g. I.U.D., Norplant)
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility. The exceptions are for prescription growth hormones or drugs provided as part of the plan's Specialty Pharmacy provision (see question 5 in "Questions And Answers About Your Pharmacy Benefits," below), which are payable under this benefit, regardless of where they are administered.
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring intravenous administration or use, and injectable medications. (The exception is self-administered injectable diabetic drugs.) Please see the Infusion Therapy benefit.
- Weight management drugs
- Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit). Please see the Medical Equipment and Supplies benefit for available coverage.
- Immunization agents and vaccines, except as stated in the Preventive Care benefit

Prior Authorization Program

To promote appropriate medication use, drugs may be subject to medical necessity review. For certain drugs, this review must occur before the drug is dispensed to you. As part of this pre-dispensing review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent medication. If you choose to purchase the medication before the pre-dispensing review has been completed, you will pay the full price for the drugs. If the review verifies the medicine use is medically necessary, then you may submit a claim for reimbursement. Please see the "How Do I File A Claim?" section in this booklet for more information.

In making these determinations, we take into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.

Contact Customer Service for details on which drugs are included in the Prior Authorization Program, or see the Pharmacy section on our Web site.

You can appeal any decision you disagree with. Please see the "Complaints And Appeals" section in this booklet, or call our Customer Service department.

Prescription Drug Volume Discount Program

Your prescription drug program includes per-claim rebates that are received by Premera Blue Cross from its pharmacy benefit manager. These rebates are paid or credited to your group plan and are not reflected in your cost-share. The allowable charge that your payment is based upon for prescription drugs is higher than the price we pay our pharmacy benefit manager for those prescription drugs. Premera Blue Cross retains the difference and applies it to the cost of our operations and the prescription drug benefit program. If your prescription drug benefit includes a copay, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowable charge.

Your Right To Safe And Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service. The phone numbers are shown inside the front cover of this booklet.

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health.

Questions And Answers About Your Pharmacy Benefits

1. **Does this plan exclude certain drugs my health care provider may prescribe, or encourage substitution for some drugs?**

   Your prescription drug benefit uses a preferred drug list. (This sometimes is referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the preferred list.

   This plan encourages the use of appropriate "generic drugs" (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. If a generic equivalent isn't manufactured, the applicable brand name copay will apply. You may request a brand name drug instead of a generic, but if a generic equivalent is available and substitution is allowed by the prescriber, you'll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name drug copay. However, if a generic substitution is not allowed by the prescriber, you'll still be required to pay the applicable brand name drug copay. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

   A "generic drug" is a prescription drug product manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

   It's important to note that this plan provides benefits for non-preferred brand name drugs, but at a higher cost to you.

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

   This Plan doesn't cover certain categories of drugs. These are listed above under "Exclusions."

   Certain drugs are subject to pre-dispensing medical necessity review. As part of this review, some prescriptions may require additional medical information from the prescribing provider, or substitution of equivalent medication. Please see "Prior Authorization Program" described above for additional detail.

2. **When can my plan change the pharmacy drug list? If a change occurs, will I have to pay more to use a drug I had been using?**

   Our Pharmacy and Therapeutics Committee reviews the drug list frequently throughout the year. This committee includes medical practitioners and pharmacists from the community. They review current medical studies and pharmaceutical information to decide which drugs to include on the list.

   Changes to our drug list do not change your benefits. The amount you pay for a drug is based on the drug's designation (as a generic or brand drug) on the date it's dispensed. The pharmacy's status as participating or non-participating on the date the drug is dispensed is also a factor.

3. **What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?**

   The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of the plan's overall benefit design, and can only be changed at the sole discretion of Weyerhaeuser. Provisions regarding substitution of generic drugs and the Prior Authorization program are described above in question #1.

   You can appeal any decision you disagree with. Please see the "Complaints And Appeals" section in this booklet, or call our Customer Service department at the telephone numbers listed inside the front cover of this booklet for information on how to initiate an appeal.

4. **How much do I have to pay to get a prescription filled?**

   The amount you pay for covered drugs dispensed by a retail or Specialty Pharmacy, or

through the Express Scripts Home Delivery pharmacy benefit is described previously.

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

   Yes. You receive the highest level of benefits when you have your prescriptions filled by participating pharmacies. **Your benefits do not cover prescription drugs dispensed from a non-participating pharmacy.**

   To find a participating pharmacy, use the Provider Directory at www.premera.com/wy or call the toll-free Pharmacy Locator Line on the back of your ID card. If you need a list of participating pharmacies, please call us (see "Who to Contact" section inside the front cover of this booklet).

   Also see "Specialty Pharmacy Program" earlier in this benefit for information on specialty drugs.

6. **How many days supply of most medications can I get without paying another copay or other repeating charge?**

   The dispensing limits (or days supply) for drugs dispensed at retail or Specialty Pharmacies and through the mail service pharmacy benefit are described in the "Dispensing Limit" provision.

   Benefits will be provided only when the member has used 75% of a supply of a single medication. The 75% is calculated based on both of the following:

   - The number of units and days' supply dispensed on the last refill
   - The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill.

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

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

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

BLUECARD• PROGRAM AND OTHER INTER-PLAN ARRANGEMENTS

Premera Blue Cross has relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program," negotiated National Account arrangements, and arrangements for payments to non-network providers. Whenever you obtain healthcare services outside Washington and Alaska or in Clark County, Washington, the claims are processed through one of these arrangements. You can take advantage of these Inter-Plan Arrangements when you receive covered services from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, you may also obtain care from non-network providers. Our payment calculation practices in both instances are described below.

It's important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

Network Providers

When you receive care from a Host Blue's network provider, you will receive many of the conveniences you're used to from Premera Blue Cross. In most cases, there are no claim forms to submit because network providers will do that for you. In addition, your out-of-pocket costs may be less, as explained below.

Under the BlueCard Program, we remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever a claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The provider's billed charges for your covered services; or
- The allowable charge that the Host Blue makes available to us.

Often, this allowable charge will be a simple discount that reflects an actual price that the Host Blue considers payable to your provider. Sometimes, it is an estimated price that takes into account special arrangements with your provider that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the allowable charge we use for your claim because they will not be applied retroactively to claims already paid.

Clark County Providers

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

Negotiated National Account Arrangement in Arizona

Members' claims for covered healthcare services in Arizona are processed through an Inter-Plan Program called a negotiated National Account arrangement with the Host Blue in Arizona. Our responsibilities and those of the Arizona Host Blue and its network providers under this arrangement are the same as under the BlueCard Program.

Allowable charge calculations under the negotiated National Account arrangement are the same as described above in the "Network Providers" section for the BlueCard Program.

BlueCard In California

We have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross of California. In order for you to maximize your savings under the BlueCard Program, you will need to choose only Anthem Blue Cross of California network providers for services received in California.

Please see "How Does Selecting A Provider Affect My Benefits?" for further details on how to lower your out-of-pocket expenses.

Non-Network Providers

When covered services are provided outside Washington and Alaska or in Clark County, Washington by providers that do not have a contract with the Host Blue, the allowable charge will generally be based on either our allowable charge for these providers or the pricing requirements under applicable state law. You are responsible for the difference between the amount that the non-network provider bills and this plan's payment for the covered services.

Exceptions Required By Law

In some cases, federal law or the laws in a small number of states may require the Host Blue to include a surcharge as part of the liability for your covered services. If either federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then use the surcharge and/or other amount that the Host Blue instructs us to use in accordance with those laws as a basis for determining the plan's benefits and any amounts for which you are responsible.

BlueCard Worldwide•

If you're outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide when accessing covered health services. BlueCard Worldwide is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although BlueCard Worldwide provides a network of contracting inpatient hospitals, it offers only referrals to doctors and other outpatient providers. Also, when you receive care from doctors and other outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you'll typically have to submit the claims yourself to obtain reimbursement for these services.

Further Questions?

If you have questions or need more information about Inter-Plan Arrangements, including the BlueCard Program, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, go to our Web site or call the toll-free BlueCard number; both are shown on the back cover of your booklet. You can also get BlueCard Worldwide information by calling the toll-free phone number.

CARE MANAGEMENT

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important.

You must be eligible on the dates of service and services must be medically necessary. A voluntary process is available to determine medical necessity prior to receiving the service. This process is a request for a Benefit Advisory. Our Practitioner Clinical Review Guideline provides a list of services that are reviewed for medical necessity. These procedures may be considered experimental or investigational, have contract limitations, or contract exclusions.

You can call Customer Service to determine if your procedure will be reviewed for medical necessity. If your procedure will be reviewed, you or your provider may fax information to 800-843-1114.

CLINICAL REVIEW

Premera Blue Cross has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria.

Our medical policies are on our Web site. You or your provider may review them at **www.premera.com**. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain the information, please send your request to Care Management at the address or fax number shown on the back cover.

Premera reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigational. A decision by Premera following this review may be appealed in the manner described in "Complaints And Appeals." When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

CASE MANAGEMENT

Case Management is a voluntary program designed to provide assistance with the coordination of health care benefits for individuals who have certain catastrophic or chronic care needs.

Specially trained nurses and social workers will use their clinical and benefit expertise to help you:

- Advocate for your health care needs
- Understand your care and coverage options
- Find the appropriate care providers
- Arrange for physician ordered services
- Access community resources
- Self-manage chronic disease

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of this plan's benefits. The decision to provide benefits for these alternatives is within the plan's sole discretion. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

Case Management is subject to the terms set forth in the signed written agreements. Your plan benefits may be utilized as specified in the signed agreements, but the agreements are not to be construed as a waiver of the right to administer the plan in strict accordance with its terms in other situations. All parties have the right to re-evaluate or terminate the Case Management agreement at any time, at their sole discretion. Case Management termination must be provided in writing to all parties. Your remaining benefits under this plan would be available to you at that time.

DISEASE MANAGEMENT

Our Disease Management program is designed to improve health outcomes for members with certain chronic diseases. The program identifies individuals who may benefit from the program and provides condition specific educational newsletters and telephonic coaching support to achieve the best possible therapeutic outcomes. A certified personal health support coach supports members by reminding them of important screenings, finding resources and developing a plan to improve their health. Participation in Disease Management programs is voluntary. To learn more about the availability of Disease Management, contact our Customer Service team at the phone number shown on the back cover of this booklet.

WHAT'S NOT COVERED?

This section of your booklet explains circumstances in which all the benefits of this plan are either limited or no benefits are provided. Benefits can also be affected by our "Care Management" provisions and your eligibility. In addition, some benefits have their own specific limitations.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, we won't provide benefits for the following:

Acupuncture

Services and supplies rendered for acupuncture.

Benefits from Other Sources

Benefits are not available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Boat coverage
- Commercial liability coverage
- Homeowner policy
- School or athletic policy
- Other types of liability insurance coverage
- Any excess insurance coverage

Benefits That Have Been Exhausted

Amounts that exceed the allowable charge or maximum benefit for a covered service.

Biofeedback Services

EEG biofeedback or neurofeedback services for medical or psychiatric conditions or biofeedback services for psychiatric conditions.

Caffeine Or Nicotine Dependency

Treatment of caffeine dependency; treatment of nicotine dependency except as stated under the Health Management, Professional Visits and Services and Prescription Drugs benefits.

Charges for Records or Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review.

Chemical Dependency

- Treatment of dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous

For chemical dependency care, please refer to the Behavioral Health Care section in this booklet.

Christian Science

Services and supplies (including drugs) rendered by a Christian Science Practitioner or a Christian Science Sanatorium.

Cosmetic Services

Services and supplies (including drugs) rendered for cosmetic purposes and plastic surgery, whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance or shape of a body structure, including any direct or indirect complications and aftereffects thereof.

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an injury, providing such repair is started within 12 months of the date of the injury
- Repair of a dependent child's congenital anomaly
- Reconstructive breast surgery in connection with a mastectomy, except as specified under the Mastectomy and Breast Reconstruction Services benefit
- Correction of functional disorders (not including removal of excess skin and or fat related to weight loss surgery or the use of obesity drugs) upon our review and approval

Counseling, Educational or Training Services

- Counseling, education or training services, except as stated under the Nutritional Therapy, Diabetes benefits, Professional Visits and Services or for services that meet the standards for preventive services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling; and family and marital psychotherapy, except when medically necessary to treat the diagnosed substance use disorder or disorders of a member
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities.
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy

Court-Ordered Services

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except as deemed medically necessary by us.

Custodial Care

Custodial Care, except when provided for hospice care (please see the Home and Hospice Care benefit).

Dental Care

Dental services or supplies, except as specified under Dental Services (please see "Medical Services" under "What Are My Benefits?").

This exclusion also doesn't apply to dental services covered under the Temporomandibular Joint (TMJ) Disorders benefit.

Drugs and Food Supplements

Over-the-counter drugs, solutions, supplies, food and nutritional supplements; over-the-counter contraceptive drugs (except as required by law), supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that do not require a prescription.

Employment-Related Conditions

- Any illness, condition or injury arising out of or in the course of employment, whether or not a proper and timely claim for such benefits has been made under:
- Occupational coverage required of, or voluntarily obtained by, the employer
- State or federal workers' compensation acts
- Any legislative act providing compensation for employment-related illness or injury

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental or Investigational Services

Any service or supply that Premera Blue Cross

determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of "experimental/investigational services" (please see the "Definitions" section in this booklet).

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the "Complaints And Appeals" section in this booklet for an explanation of the appeals process.

However, exclusions for experimental or investigational treatment will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Premera Blue Cross determines that:

- The disease can be expected to cause death within one year in the absence of effective treatment; and
- The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, Premera Blue Cross will take into account the results of a review by a panel of independent medical professionals. They will be selected by Premera Blue Cross. This panel will include professionals who treat the type of disease involved

Also, exclusions for experimental or investigational treatment will not apply with respect to drugs:

- That have been granted treatment investigational new drug (IND) or group treatment IND status; or
- That are being studied at the Phase III level in national clinical trial sponsored by the National Cancer Institute

If Premera Blue Cross determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

Family Members or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

Gender Transformations

Treatment or surgery to change gender, including any direct or indirect complications and after effects thereof.

Governmental Medical Facilities

Services and supplies furnished by a governmental medical facility, except when:

- Your request for a benefit level exception for non-emergent care to the facility (please see the "Benefit Level Exceptions For Non-Emergent Care" provision in this booklet) is approved.
- You're receiving care for a "medical emergency" (please see the "Definitions" section in this booklet).
- The plan must provide available benefits for covered services as required by law or regulation.

Hair Loss

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth
- Hair prostheses, such as wigs or hair weaves, transplants, and implants

Hearing Exams and Testing

Routine hearing exams and testing, including those necessary for the evaluation of the need for hearing aids.

Hearing Hardware

Hearing aids and devices used to improve hearing sharpness.

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Specialty Pharmacy Program (please see the Prescription Drugs benefit) and are not covered to treat idiopathic short stature without growth hormone deficiency.

Illegal Acts and Terrorism

This plan does not cover illness or injuries resulting from a member's commission of:

- A felony (does not apply to a victim of domestic violence)
- An act of terrorism
- An act of riot or revolt

Medical Equipment and Supplies

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities

- Penile prostheses
- Prosthetics, appliances or devices requiring surgical implantation. When eligible, these items are covered under the Surgical Services benefit
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications, except as specified in the Prescription Drugs benefit

Mental Health Care

Treatment of all psychiatric conditions; treatment of eating disorders, such as anorexia nervosa, bulimia, or any similar conditions.

For mental health care benefits, please refer to the Behavioral Health Care section in this booklet.

Military Service and War

This plan does not cover illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

No Charge or You Do Not Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you do not legally have to pay, except as required by law in the case of federally qualified health center services

Not Covered

- Services or supplies ordered when this plan isn't in effect, or when the person isn't covered under this plan
- Services or supplies provided to someone other than the ill or injured member, other than outpatient health education services to manage the condition of diabetes covered under the Diabetes Health Education benefit
- Services and supplies that are not listed as covered under this plan
- Services and supplies directly related to any condition, complications, or related to any other service or supply that isn't covered under this plan
- Members and this plan are not responsible for payment of services provided by network providers for "serious adverse events," "never events" and resulting follow-up care. "Serious adverse events" and "never events" are medical errors that are specific to a nationally published list. They are identified by specific diagnosis codes, procedure codes and specific present-on-admission indicator codes. A "serious adverse event" means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Network providers may not bill members for these services and members are held harmless.

Not In the Written Plan Of Care

Services, supplies or providers not in the written plan of care or treatment plan, or not named as covered in the Home and Hospice Benefit, Neuropsychological Testing, Rehabilitation Therapy and Chronic Pain Care benefits.

Not Medically Necessary

Services or supplies that are not medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care.

Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary.

Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition.

Obesity Services

Treatment of obesity or morbid obesity, including surgery, and any direct or indirect complications and aftereffects thereof; (An example of an aftereffect that would not be covered is removal of excess skin and or fat that developed as a result of weight loss surgery or the use of obesity drugs) along with services and supplies connected with weight loss or weight control. This exclusion applies even if you also have an illness or injury that might be helped by weight loss.

On-Line and Telephone Consultations

Electronic, on-line, internet or telephone medical consultations or evaluations.

Orthodontia Services

Benefits are not provided for orthodontia, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers. The exceptions are for services provided for treatment of a cleft palate, or other severe craniofacial anomalies for children under the age of 16.

Outside the Scope of a Provider's License or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received.

Personal Comfort or Convenience Items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home and Hospice Care benefit); and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance, except as specified under the Nutritional Therapy benefit

Private Duty Nursing Services

Private duty nursing

Rehabilitation Services

Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary; except for Chronic Pain Care

Routine or Preventive Care

- Routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof, except as stated under the Professional Visits and Services benefit; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. This includes foot-support supplies, devices and shoes, except as stated under the Medical Equipment and Supplies benefit
- Exams to assess a work-related or medical disability
- Charges for services or items that don't meet the federal guidelines for preventive services described in the Preventive Care benefit, except as required by law. This includes services or items provided more often than stated in the guidelines.

Serious Adverse Events and Never Events

- Members and this plan are not responsible for payment of services provided by network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. Network providers may not bill members for these services and members are held harmless.
- Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
- Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.
- Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) Web page at **www.cms.hhs.gov**.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including penile or other implants; and, any direct or indirect complications and aftereffects thereof.

Skilled Nursing Facility Coverage Exceptions

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency

Transplant Coverage Exceptions

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and after effects thereof, except as specifically stated under the Transplant benefit
- Services or supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers
- Donor costs for a organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplant benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they are not "experimental/investigational services" (please see the "Definitions" section in this booklet)

Vision Hardware

Vision hardware (and their fittings) used to improve

visual sharpness, including eyeglasses and contact lenses, and related supplies are only covered as described in the Vision Hardware benefit, if this plan includes one, and the Medical Equipment and Supplies benefit.

Services that will not be covered regardless are:

- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Services and supplies (including hardware) received after your coverage under this plan has ended, except when all of the following requirements are met:
- You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this plan ended
- You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this plan ended

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of complications.

Work-Related Conditions

Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

- Occupational coverage required of, or voluntarily obtained by, the employer
- State or federal workers' compensation acts

Any legislative act providing compensation for work-related illness or injury.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

You also may be covered under one or more other group or individual plans, such as one sponsored by your spouse's or domestic partner's employer. Because all of the benefits of this plan are subject to coordination of benefits, this plan includes a "coordination of benefits" feature to handle such situations. We'll coordinate the benefits of this plan with those of your other plans to make certain that, in each calendar year, the total payments from all medical plans are not more than the total allowable medical expenses. In order to process your claim in these instances, Premera Blue Cross requires that you send us a copy of the EOB from your primary insurance carrier along with your claim.

Definitions Applicable to Coordination of Benefits

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under any of the medical plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Claim Determination Period** means a calendar year.
- **Medical Plan** means all of the following health care coverages, even if they do not have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents
  - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation
  - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease

Each contract or other arrangement for coverage described above is a separate plan.

Effect on Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." This means they reduce their payment amounts so that the total benefits from all medical plans are not more than the allowable medical expenses. Coordination of benefits always considers amounts that **would** be payable under the other plan, whether or not a claim has actually been filed.

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

First: A plan that doesn't provide for coordination of benefits.

Next: A plan that covers you as an employee or subscriber. If you are covered as a subscriber under more than one plan, the plan that covers you as an active employee.

Next: A plan that covers you as a dependent. For dependent children, the following rules apply:

When the parents **are not** separated or divorced:

The plan of the parent whose birthday falls earlier in the year will be primary, if that's in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan that doesn't have this provision shall determine the order of benefits.

When the parents **are** separated or divorced:

If a court decree makes one parent responsible for paying the child's health care costs, that parent's plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who doesn't have custody.

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

Any amount by which a secondary plan's benefits have been reduced in accord with this section shall be used by the secondary plan to pay your allowable medical expenses not otherwise paid, and such reduced amount shall be charged against the applicable plan's benefit limit. However, you must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for allowable medical expenses based on all claims that were submitted up to that time during the claim determination period.

Right of Recovery/Facility of Payment

We have the right to recover any payments we make that are greater than those required by the coordination of benefits provisions from one or more of the following: the persons we paid or for whom we have paid, providers of service, insurance companies, service plans or other organizations. If a payment that should have been made under this plan was made by another plan, we also have the right to pay directly to another plan any amount that should have been paid by us. Our payment will be considered a benefit under this plan and will meet our obligations to the extent of that payment.

Coordinating Benefits with Medicare

If you're also covered under Medicare and/or TRICARE, this plan is generally considered to be primary.

When this plan isn't primary, we'll coordinate benefits with Medicare and/or TRICARE.

If you are covered by Medicare due to End Stage Renal Disease (ESRD) this plan will be primary for the first 30 months, or as required under Medicare Secondary Payer rules.

SUBROGATION AND REIMBURSEMENT

If the plan pays benefits on your behalf or on the behalf of a covered person for injury or illness for which another party may be liable or legally responsible to pay, the plan has first priority right of reimbursement, to the extent of benefits paid, from monies recovered because of the injury or illness.

An "other party' in this context is defined to include, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness, or bodily injury, or
- The insurer or other indemnifier of the party or parties who caused the illness, sickness, or bodily injury, or
- The covered person's own insurer (for example, in the case of Uninsured Motorist [UM], Underinsured Motorist [UIM], medical payments or no-fault coverage), or
- A worker's compensation insurer, and/or
- Any other person, entity, policy, or plan that is liable or legally responsible in relation to the illness, sickness, or bodily injury.

When benefits are payable under this plan in relation to illness, sickness, or bodily injury, the plan may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the other party. The covered person or his or her legal representative will transfer to the plan any rights he or she may have to take legal action arising from the illness, sickness, or bodily injury to recover any sums paid under the plan on behalf of the covered person. This is the plan's right of subrogation.
- Recover from the covered person or his or her legal representative any benefits paid under the plan from any payment of the covered person is entitled to receive from the other party. This is the plan's right of reimbursement.

The plan's first priority right of reimbursement will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs.

The plan will be reimbursed whether the judgment, settlement, or other payments allocate any specified amount to reimbursement for medical expenses, and regardless of whether such expenses are paid prior to or after the date of such judgment, settlement, or otherwise.

The plan will have first priority reimbursement rights from any recovery, whether by settlement, judgment, mediation, or arbitration, that the covered person receives or is entitled to receive from any of the sources previously identified above. This reimbursement will not exceed:

- The amount of benefits paid by the plan for the illness, sickness, or bodily injury, plus the amount of all future benefits which may become payable under the plan which result from the illness, sickness, or bodily injury. The plan will have the right to offset or recover such benefits from the amount received from the other party, and/or
- The amount recovered from the other party.

If the covered person or his or her legal representative makes a recovery from any of the sources previously identified above and fails to reimburse the plan for any benefits which may arise from the illness, sickness, or bodily injury, then the plan may reduce future benefits payable under this plan for any illness, sickness, or bodily injury by the payment that the covered person or his or her legal representative has received from the other party.

The plan's right of reimbursement also applies to any funds recovered from the other party by or on behalf of:

- A covered dependent, or
- The estate of any covered person, or
- On behalf of any incapacitated person.

Before accepting any settlement or recovery on a claim against another party, the covered person or his or her legal representative must notify us in writing of any terms or conditions offered in a settlement, and the covered person or his or her legal representative must notify the other party of our interest in the settlement established by this provision.

The covered person or his or her legal representative must cooperate fully with the plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative will, within 14 business days of receiving a request from the plan, provide all information and sign and return all documents necessary to exercise the plan's rights under this provision.

The covered person or his or her legal representative must also cooperate with us in recovering amounts paid by the plan on behalf of the covered person. If the covered person or his or her legal representative fails to cooperate fully with the plan in recovery of benefits we have paid as described above, the covered person or his or her legal representative will be personally liable to the plan for the amount paid on the covered person's behalf under the plan.

In the event that there is a disagreement regarding reimbursement of the plan's subrogation amount at the time of settlement, the covered person or his or her legal representative agrees to hold any recovered funds in trust or in a segregated account until the plan's subrogation and reimbursement rights are fully determined.

Benefits are not available under this plan when coverage is available through:

- Personal Injury Protection (PIP) coverage, or
- Motor vehicle medical (Medpay) or motor vehicle no-fault coverage, or
- Worker's Compensation, Labor and Industry, or similar coverage, or
- Any excess insurance coverage, or
- Medical premises coverage, or
- Commercial liability coverage, or
- Boat coverage, or
- Homeowner’s policy, or
- School and/or athletic policies, or
- Other type of liability or insurance coverage.

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage.

Please note that you do not have to be a citizen of or live in the United States if you are otherwise eligible for coverage.

SUBSCRIBER ELIGIBILITY

You are eligible to be covered by this plan if you are an employee and on the payroll of Weyerhaeuser Company or a participating company as described below:

- An eligible hourly production employee who works for Weyerhaeuser on a full-time basis.
- A member of a union that has agreed to provide this plan and who meets the benefits eligibility requirements as defined by the labor contract.

Temporary employees are not eligible for coverage under the plan regardless of the number of hours worked.

DEPENDENT ELIGIBILITY

As an employee enrolling in this plan, you may elect coverage for your eligible dependents under the plan. Only the dependents who meet the eligibility requirements and rules are eligible for plan coverage. Use this information as a guide to ensure each dependent you enroll in the plan meets plan eligibility requirements and rules.

Coverage Category	Eligible for benefit coverage if....
Spouse	You elect coverage for yourself, and your spouse is legally married to you. You may not cover a spouse from whom you are currently divorced or legally separated. Note: Weyerhaeuser-sponsored plans do not recognize (and are not required to recognize) any court-approved divorce decree that requires continued benefit coverage for your former spouse.
Domestic Partner Note: Some plans allow you to cover a domestic partner; for more information, call the ESC at 800.833.0030	You elect coverage for yourself, and you and your domestic partner are both all of the following: • In an exclusive, long-term, committed relationship with each other • Living together, and have done so continuously for at least six months immediately prior to requesting coverage, with the intention to do so indefinitely • At least 18 years old • Financially interdependent with each other • Unrelated by blood • Not legally married to anyone else or a member of another domestic partner relationship • Mentally competent to make a contract To enroll, you must complete and return the Declaration of Domestic Partner Status form to the ESC. Note: Special rules apply if you want to end coverage mid-year due to your relationship ending. Call the ESC for more information.
Child (Minor children and young adults)	You elect coverage for yourself (and your domestic partner, if covering your domestic partner's child) and the child is under age 26 and is your (or your domestic partner's): • Natural or legally adopted child *or* your step child • Eligible foster child, if placed by an authorized placement agency or by judgment or decree • Child placed in your home for adoption • Child for whom you, your spouse, or your domestic partner have court-appointed guardianship or for whom you have a Qualified Medical Child Support Order (QMCSO) Note: While you may cover your married or unmarried young adult child, you may not cover his/her spouse or children.
Disabled Child	Your adult child may be eligible to remain covered under your plan indefinitely if he or she meets all of the requirements for a child (above) and meets the following additional requirements. Your adult child must also be disabled and *all of the following*: • Enrolled in the plan on the date he or she otherwise would become ineligible for coverage due to plan age requirements, even if all other criteria are met • Your adult child must be disabled. That is, deemed disabled by the plan administrator or designee, as applicable. Ongoing proof of disability is required; failure to respond to requests for disability information will result in coverage being terminated. • Unable to earn a living because of a continuous physical, developmental, or mental disability that began before age 26 • Unmarried • Living with you and not providing more than half of his or her support, or you (or your spouse or domestic partner) provide 50% or more of his or her financial support, regardless of whether the child is living with you • Not covered by another group health plan as an employee • Coverage for the disabled child can be continued for as long as both you and your child remain enrolled in the plan and the disabled child remains eligible for coverage

Important
Call the Employee Service Center at 800-833-0030 to request continued coverage at least 31 days before the disabled child's 26th birthday.

Dual-Coverage. If both you (the employee) and your spouse or domestic partner is eligible to enroll in this plan as Weyerhaeuser employees, you have two options for coverage:

- You both may enroll as an employee. In this case, each eligible child, can be covered only under your plan or your spouse's or domestic partner's plan (not both), and one spouse/domestic partner cannot be covered as a dependent of the other. Neither you nor your spouse (or domestic partner) or children may be enrolled twice in this plan.
- One of you may enroll as employee and the other may be covered (along with any eligible children) as a dependent under that person's coverage.

Certification and documentation of eligible dependents

Any time you elect or maintain coverage for your dependents (e.g., spouse, child, domestic partner, or domestic partner's child), you certify that they are eligible dependents under the plan. You are always responsible for notifying the ESC as soon as possible, but no later than 31 days after any changes that may affect the eligibility of your dependents for coverage under the plan.

Periodically you will be required to certify your dependents' plan eligibility; you may also be required to periodically provide documentation that proves your dependent's eligibility. Failure to provide any of the requested certifications or documentation may interrupt or delay coverage under the plan. Weyerhaeuser retains the right to conduct periodic audits of eligible dependents at any time.

Fraudulent coverage of dependents

Weyerhaeuser monitors the eligibility of dependents through periodic audits and investigations. If it is determined that you fraudulently elected or maintained coverage for that dependent, you may be required to reimburse the cost of any claims or expenses paid under the plan for the ineligible dependent. In addition, Weyerhaeuser reserves the right to permanently terminate plan coverage for you and your dependents for fraudulently electing or maintaining coverage for an ineligible dependent. Any employee who fraudulently enrolls or maintains plan coverage for an ineligible dependent may also be subject to disciplinary action, up to and including termination of employment or legal action.

Qualified Medical Child Support Orders. The plan complies with Qualified Medical Child Support Orders (QMCSOs). You can obtain a copy of the plan's procedures for QMCSOs free of charge, by contacting the Weyerhaeuser HR Help Line to reach the Employee Service Center.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

When you become an eligible employee, you may enroll yourself and/or your eligible dependents during your first 31 days of work or during the annual open enrollment period. After you elect to enroll, coverage begins the earlier of either the first day of the month following one month of continuous employment, or January 1st following the open enrollment period.

If you do not enroll in the plan, you will not be covered and will be considered to have waived coverage under the plan. Unless you have a qualifying status change, you must wait until the next open enrollment to enroll in the plan.

HOW TO ENROLL

Weyerhaeuser provides plan enrollment information soon after your date of hire; you will also receive login information to access the online benefits enrollment tool. You must complete enrollment within 31 days after your first day of work. For more information, call the Weyerhaeuser ESC at 800-833-0030.

WHEN CAN COVERAGE BE CHANGED?

You may make changes to your coverage during any annual open enrollment period or within 31 days after a qualifying status change or event as described below:

CHANGES IN COVERAGE

Changes during Open Enrollment

Medical coverage for you and your dependent(s) begins January 1 of the following year if you enroll during annual open enrollment. Once you enroll in coverage, your election will generally carry forward into the next calendar year/benefits period.
If you waive coverage or do not enroll when you first become eligible, or as allowed under "Changes during the Year," you may change your medical election only during annual open enrollment.
During annual open enrollment, you may:

- Enroll yourself, your eligible spouse/domestic partner, eligible children, and your eligible domestic partner's children.
- If you are already enrolled, you may add your eligible spouse/domestic partner, eligible children, and your eligible domestic partner's children.

- Stop coverage for yourself or any covered dependent(s).

All changes in medical coverage made during annual open enrollment become effective on January 1 of following year.

Changes during the Year

If you experience a special enrollment event or qualifying status change, you may:

- Enroll for the first time (if you previously elected to waive coverage).
- Change your existing medical coverage election.

Generally, any election change must be consistent with the qualifying status change that affects eligibility for you, your spouse/domestic partner, your dependent children, or your domestic partner's dependent children under this plan or another employer's plan. Otherwise, you may make changes only during open enrollment.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT EVENTS

If you experience certain mid-year changes in eligibility for benefits under this plan, you may be eligible for HIPAA special enrollment rights. These rights and the plan allow you to add yourself, if you are not already enrolled *and* any eligible dependents to this plan (even if your other eligible dependents are not directly affected by the event) as long as you enroll within 31 days after the event. You may also enroll in any medical plan option that is offered to you. These options are available under the following circumstances:

- You gain a new dependent because of marriage, birth, adoption, or placement for adoption.
- You decline enrollment when initially eligible for yourself, your spouse/domestic partner, and/or your or your domestic partner's dependent children because you (or they) have other medical coverage and eligibility for such coverage is subsequently lost.
- Coverage loss must be due to loss of eligibility for the other medical coverage other than coverage through Medicare or TRICARE. This includes loss due to divorce, termination of domestic partner relationship, death, termination of employment, or reduction in hours of employment, or moving outside of a health maintenance organization plan's service area with no other coverage available from the other employer.
- If your other medical plan was through COBRA continuation coverage from a previous employer, you must exhaust your COBRA coverage to be eligible for the special enrollment period.
- If you and/or your dependents becomes eligible to add plan coverage due to loss of eligibility for Medicaid or a State Children's Health Insurance Program (CHIP); or is determined to be eligible for assistance with the cost of participating in the plan through the Medicaid plan or the State CHIP plan in which you and/or your dependent participate, you may request enrollment in this plan within 60 days of the loss of coverage under Medicaid or CHIP or 60 days from the date you become eligible for the premium subsidy. (See Appendix for additional information about this program.)

IMPORTANT

Adding or Dropping Coverage? If you have a special enrollment event or qualifying status change that allows you to become eligible for coverage during the plan year, or allows you to drop coverage for yourself or a dependent, you have 31 days after the date of the special enrollment event or qualifying status change to notify the ESC. Coverage begins on the date of the change if you provide notification within the 31-day period.

Note: If you and/or your dependent becomes eligible for Special Enrollment rights through Medicaid or Children's Health Insurance Program (CHIP) and you wish to enroll in this plan, you must do so within 60 days of the event.

If you have a qualifying status change that requires you to drop coverage for a dependent during the plan year, you have 60 days after the date of the qualifying status change to stop plan coverage. Coverage ends on the last day of the month following the status change. Premium refunds are not processed if you fail to notify the ESC of the change within the prescribed timeframe.

Call the Weyerhaeuser ESC for additional information at 800-833-0030.

QUALIFYING STATUS CHANGES

If you experience one of the qualified status changes listed below, you may be able to enroll in plan coverage, change your current plan coverage, or drop your plan coverage during the year. Any change to your plan coverage must be consistent with the status change that affects your or your dependent's eligibility for company-sponsored plan coverage or coverage sponsored by your eligible dependent's employer. The following qualifying status changes allow you to change your medical coverage mid-year:

- **Legal marital or domestic partnership status.** You marry, divorce, or legally separate; your marriage is annulled; your domestic partner newly meets plan requirements, or your domestic partner relationship ends.
- **Employment status.** Your or your eligible dependent's job situation changes due to

termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, a change between a salaried and an hourly position, a change between a part-time and a full-time position, or a change between a salaried non-union position and a union-represented position. If you, your spouse/domestic partner, or dependent child gains eligibility under another employer's plan as a result of a job situation change, your election to stop or change plan coverage will correspond with that status change only if coverage for that individual becomes effective or is increased under the other employer's plan.

- **Leave of absence.** You take an approved unpaid leave of absence in accordance with the Family and Medical Leave Act (FMLA). See "Leave of Absence" for more information.
- **Number of dependents.** You lose a dependent through death, divorce, legal separation, or end of a domestic partnership; you add a dependent through birth, marriage, establishment of a valid domestic partnership, adoption or placement of a child in your home for adoption, or court-appointed guardianship for which you have a legal and financial support obligation.
- **Dependent child's eligibility.** You or your domestic partner's child becomes eligible or ineligible for coverage (e.g., the child can no longer be covered because he or she turns 26.

Judgment, decree, or court order. You receive a judgment, decree, or court order (e.g., a Qualified Medical Child Support Order) that requires you to add or remove medical coverage.

Cost or change in coverage. If the cost of coverage changes during a plan year by an insignificant amount, your monthly contribution is automatically adjusted. If the cost or level of coverage changes significantly during a plan year, you may make election changes. The plan administrator determines if a change in cost or level of coverage is significant.

- **Entitlement to Medicare.** You or your dependent becomes eligible for Medicare.
- **Coverage changes due to different enrollment periods under a spouse's/domestic partner's benefit plans.** You may add or stop coverage for a spouse/domestic partner or dependent child if the change is due to and corresponds with a change made under a cafeteria plan or qualified benefit plan of your current or former spouse's/domestic partner's or dependent child's employer, and the other plan's coverage period differs from this plan's coverage period. (For example, if your spouse's coverage period is from May 1 to April 30, and he or she drops coverage under that plan, you may enroll your spouse for coverage under the plan.)

WHEN COVERAGE ENDS

Coverage category	Plan coverage ends as described below
Your plan coverage	At the end of the month you are no longer eligible; if you qualify for retirement, there is a one-month extension of active coverage for you and your eligible dependents
Your spouse's/ domestic partner's plan coverage	• The date your coverage ends, unless your coverage ends due to your death, or • The last day of the month in which your marriage is annulled or you become legally separated or divorced, or • The last day of the month in which your domestic partner relationship ends, or • The last day of the month in which your spouse/domestic partner becomes ineligible for any other reason
Your or your domestic partner's child's plan coverage	The date your coverage ends, unless your coverage ends due to your death The last day of the month in which your child becomes ineligible, for the following reasons: • Turns age 26 • If your spouse or domestic partner become ineligible due to marital or relationship status, your stepchildren or domestic partner's children become ineligible • Your disabled child over age 26 is no longer disabled or incapacitated or no longer meets the plan criteria to participate in such coverage

CERTIFICATE OF HEALTH COVERAGE

When your coverage under this plan terminates, you'll receive a "Certificate of Health Coverage." The certificate will provide information about your coverage period under this plan. When you provide a copy of the certificate to your new health plan, you may receive credit toward any waiting period for pre-existing conditions, if your new plan includes one. You'll need a certificate each time you leave a health plan and enroll in a plan that has a waiting period for pre-existing conditions. Therefore, it's important for you to keep the certificate in a safe place.

If you haven't received a certificate, or have misplaced it, you have the right to request one from the Weyerhaeuser ESC within 24 months of the date coverage terminated.

When you receive your Certificate of Health Coverage, make sure the information is correct. Contact the ESC if any of the information listed isn't accurate.

HOW DO I CONTINUE COVERAGE?

CONTINUATION OF GROUP COVERAGE

Leave Of Absence

Taking a leave of absence affects your medical coverage, as indicated in the following table.

Leave of absence	How your medical coverage is affected
Unpaid nonmedical leave	Generally, coverage ends on the last day of the month in which you begin your leave (coverage may be continued by paying your premium directly or through COBRA)
FMLA leave **Disability/medical leave**	Coverage is extended for all or a portion of your paid disability or FMLA medical leave. Deductions for your contributions continue while you receive pay from Weyerhaeuser (either active pay or short term disability payments) After you stop receiving pay, Weyerhaeuser generally continues your coverage for an interim time period. The coverage continuation period, which includes your deductions and the company's contribution, will not exceed 26 weeks. After that time, you and/or your covered dependents may continue coverage through COBRA, if you pay the full or a portion of the premium associated with coverage. Continuation and cost is based on the length and type of leave of absence. If you do not return to work after an FMLA leave or your FMLA leave ends before your return to work, you and/or your covered dependents may continue coverage through COBRA In some cases, Weyerhaeuser may recover premiums it paid for maintaining your medical coverage during your leave if you do not return to work
Military leave	Coverage continues during any portion of your paid military leave; coverage ends on the last day of the month in which you receive your final paycheck You may continue coverage through COBRA for up to 24 months by paying the full premium plus a 2% administrative fee
Other paid leave	Coverage continues during your paid leave; coverage ends on the last day of the month in which you receive your final paycheck

Note: If you become terminally ill and you have ten or more years of Weyerhaeuser vested service and are under age 55, your dependents may be eligible for early commencement of retiree medical care under certain circumstances following your death.

For specific details and more information about how your leave of absence will affect your other benefits, contact the Weyerhaeuser ESC at 800-833-0030.

COBRA (Consolidated Omnibus Budget Reconciliation Act Of 1985)

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, which requires continuation of medical coverage to certain eligible

employees and family members whose coverage would otherwise terminate.

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

Continuation of coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, your domestic partner, your dependent children or your domestic partner's dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

You and your covered family members may continue your current medical coverage if it ends because of one of the following qualifying events:

- You voluntarily terminate employment with Weyerhaeuser
- Weyerhaeuser ends your employment for any reason, unless you are terminated because of gross misconduct
- The number of hours you are scheduled to work are reduced below those required for you to be eligible for benefits
- You take a leave of absence

COBRA coverage also is available to your covered family members if their coverage would otherwise end because of one of the following qualifying events:

- Your death
- Your divorce, legal separation, or end of your domestic partner relationship
- Your covered child or your domestic partner's covered child becomes ineligible for coverage

COBRA coverage continues for up to 18, 24, 29 or 36 months, depending on how you or your covered dependents become eligible. (See the table below.) If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

If you or your covered dependent is disabled as determined by the Social Security Administration anytime during the first 18-month COBRA period, you must notify the COBRA administrator, SHPS, in writing (see the Contact section in the front cover of this booklet for address information), of the Social Security award within 60 days after it is granted and during the first 18-month COBRA period so that you and your covered dependents can qualify for an additional 11 months of coverage.

When the qualifying event is the reduction of employee's hours of employment due to an employee being called to active military duty, COBRA continuation coverage lasts for up to 24 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for the employee's family members who are qualified beneficiaries and who lost coverage as a result of the qualifying event, can last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse or domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the covered members of your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the covered family members if the employee or former employee dies, or gets divorced or legally separated, or the employee's domestic partner relationship ends, or if the covered child stops being eligible under the plan as a ***dependent*** child, but only if the event would have caused the family member to lose coverage under the plan had the first qualifying event not occurred. You must notify Weyerhaeuser's COBRA administrator SHPS, at the address in the Contact section in the front of this booklet, to extend coverage within 60 days.

Maximum Length of COBRA coverage	**Reason coverage stops**
18 months	• You resign • Your employment ends • Your hours are reduced and you are no longer eligible for benefits under the terms of the plan

	• You take an unpaid leave of absence (coverage can be continued for the duration of the leave or 18 months, whichever is less). For FMLA leaves, the 18-month COBRA period does not start until the FMLA leave is over.
24 months	• You take an unpaid military leave as a result of being called to active military duty.
29 months	• The Social Security Administration determines that you or your family member was permanently disabled at any time during the first 60 days of continuation coverage. • You and your dependents provide notice of the Social Security Administration's determination before the end of the initial 18 months of the COBRA period. • You notify the COBRA administrator of the Social Security award within 60 days after it is granted and during the first 18-month COBRA period.
36 months (for family members)	• You die • You divorce or legally separate • Your domestic partnership relationship ends • Your dependent stops being eligible for coverage.

Electing COBRA

You and your covered family members will receive election forms and more information about COBRA from SHPS, the COBRA Administrator. In the case of a divorce, legal separation, end of domestic partner relationship, or the ineligibility of a dependent child, you or your covered family members must call the Weyerhaeuser ESC at 800-833-0030, within 60 days of becoming eligible to elect COBRA. **If you do not notify the ESC within the 60 day notice period you will lose your right to elect COBRA**.

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your company coverage ends or 60 days after the date you receive the election form and the notice of COBRA rights mailed to you by SHPS, whichever is later. **If you do not submit a completed election form by this due date, you will lose your right to elect COBRA**. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA.

If you elect COBRA coverage because of your terminated employment, your reduced hours, or your leave of absence, and the Social Security Administration determines that you or your covered family members were permanently and totally disabled at any time during the first 60 days of the date of continuation coverage, you or your covered family member must notify the SHPS in writing (see the Contact section in the front of this booklet for address information) within 60 days of the determination. The notice must be received by SHPS within the initial 18 months of COBRA coverage so that you and your covered family member can qualify for an additional 11 months of coverage.

A note about COBRA and Medicare coverage:

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that determine which one pays first. The "primary payer" pays what it owes on your bills, and then sends them to the "secondary payer" to pay. If you, your spouse, or your eligible domestic partner are age 65 or older and still working, or disabled and entitled to enroll in Medicare, you may have deferred enrollment in Medicare Parts A and/or B until your active coverage ended. If you, your spouse, or eligible domestic partner are offered COBRA as a result of loss of active coverage, Medicare becomes your primary payer on the date that your active coverage ends. It is important to consider enrolling in Medicare at that time to ensure that you have primary coverage. (If you are eligible for Medicare based on End-Stage Renal Disease, Medicare is a secondary payer to your COBRA coverage for a period of time as specified by Medicare Secondary Payer rules.) These rules for enrolling in Medicare and determining the manner in which plan benefits are coordinated are complex. For further information, please contact Social Security at 800-772-1213. TTY uses should call 800-325-0778.

If you, your spouse, or eligible domestic partner has already enrolled in both Parts A and B of Medicare at the time of your loss of active coverage, you may also enroll in COBRA coverage, as long as your COBRA election is made after your Medicare effective date.

Required notices from qualified beneficiaries

To request COBRA continuation coverage, you or your covered family members are required to notify

the ESC (see the contact list in the front of this booklet) in writing or by phone within a maximum of 60 days after any of the following qualifying events:

- Your divorce or legal separation
- The end of your domestic partner relationship
- A dependent child becomes ineligible for coverage

You will be given at least 60 days from the date coverage ends or the date you receive the COBRA notice and election forms, whichever is later, to elect COBRA.

If you have elected COBRA continuation, you or your covered family members are also required to notify SHPS in writing (see the Contact section in the front of this booklet for address information) within a maximum of 60 days after any of the following:

- a second qualifying event such as divorce, legal separation, death or dependent child ceasing to be a dependent, or Medicare entitlement
- Social Security Administration determination of disability
- Social Security Administration determination of cessation of disability

The notification must include:

- your name
- your address
- your relationship to the employee
- a description and date of the qualifying event

More information about individuals who may be qualified beneficiaries

Children born to or placed for adoption with the covered employee during COBRA period:

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as the COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs:

A child of the covered employee who is receiving benefits under the plan pursuant to a qualified medical child support order (QMCSO) received by Weyerhaeuser during the covered employee's period of employment with Weyerhaeuser is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When COBRA ends

COBRA coverage ends when the earliest of the following events occurs:

- The maximum COBRA period - 18, 24, 29 or 36 months – ends.
- Premiums are not made on a timely basis.
- Weyerhaeuser terminates the plan or amends the plan to eliminate coverage and does not provide any other group health plan to employees.
- The person who elected COBRA becomes covered under another group health plan after he or she has elected to continue coverage through COBRA and meets any pre-existing condition prohibitions or limitations affecting the person.

Trade Act of 2002

The Trade Act of 2002 provides for health care coverage expansion to certain employees who have lost their jobs or had a reduction in hours as a direct result of competition from foreign trade or production being moved overseas. As a result of this Act, affected employees may be eligible for a second 60-day COBRA election period if they did not elect COBRA continuation coverage when first eligible. This second election period begins on the first day of the month that the employee is determined to be eligible for trade adjustment assistance (TAA).

In addition, TAA-eligible employees may also qualify for a federal tax credit of 65% of the COBRA premiums if they elect COBRA coverage. If you are eligible for this tax credit, there are two options available for receiving this credit:

- Elect to claim the 65% credit on the annual federal tax return
- Obtain an advance credit of 65% and thereby pay the 35% balance of the monthly premium

You will be notified if you are determined to be TAA-eligible. If you have any questions regarding the Trade Act of 2002 or your eligibility for TAA assistance, contact SHPS.

COBRA General Notice

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) is a federal law requiring employers to offer continued benefits coverage to employees and/or their covered dependents in circumstances in which coverage would generally otherwise end. When a participant continues coverage through COBRA, he or she is responsible for paying the full cost of coverage each month (the full premium), plus a 2% administration fee.

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

CONTINUATION UNDER USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights to employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

HOW DO I FILE A CLAIM?

Medical Claims

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

Step 1

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service or going to **www.premera.com/wy**

Step 2

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or diagnosis code from the most current edition of the **International Classification of Diseases** manual.
- Procedure codes from the most current edition of the Current Procedural Terminology manual, the Healthcare Common Procedure Coding manual, or the American Dental Association Current Dental Terminology manual for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an injury, the date, time, location and a brief description of the event.

Step 3

If you're also covered by Medicare, in most cases your claims will be automatically submitted to Premera Blue Cross once Medicare has paid their portion. Your claim will be processed and you will receive an Explanation of Benefits (EOB). If we make a benefit payment, the payment will be automatically sent to your provider. In the rare event a claim is not automatically submitted to Premera Blue Cross, attach a copy of the "Explanation of Medicare Benefits."

Step 4

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

Mail Your Claims To:

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

Vision Claims

Vision Hardware Claims

You must pay for services upfront, then complete a Subscriber Claim Form and attach an itemized bill. Any applicable payment will be sent to you. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service or going to **www.premera.com/wy.** If you need to submit a claim to us, follow the steps listed above.

Vision Exam Claims for a Non-Preferred Provider

You must pay for services upfront, then complete a Subscriber Claim Form and attach an itemized bill. Any applicable payment will be sent to you. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service or going to **www.premera.com/wy.** If you need to submit a claim to us, follow the steps listed above.

Vision Exam Claims for a Preferred Provider

Most preferred providers will submit their bills to their local Blue Cross / Blue Shield plan and will be subject to the terms of their contract with the local Blue Cross / Blue Shield; or you may opt to submit to us directly. However, if you need to submit a claim to us, follow the simple steps listed above.

Please submit vision claims to:

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

Prescription Drug Claims

Your benefits only cover prescription drugs dispensed from a pharmacy participating in the Express Scripts network.

Participating Pharmacies

For retail purchases from a participating pharmacy, you do not have to send us a claim. Just show your ID card to the pharmacist, who will bill us directly. To receive the highest level of benefits, be sure to present your ID card to the pharmacist for all prescription drug purchases.

If you do not show your ID card, you'll have to pay the full cost of the prescription and submit the claim yourself. You will be reimbursed at a lower allowable charge for the prescription, minus your copay. Be sure to keep your prescription drug receipt(s).

Call Customer Service to request an Express Scripts direct reimbursement claim form, or download a form online at **www.premera.com/wy**. Complete and send the claim form and a copy of your receipts(s) to the address on the claim form.

For mail service pharmacy purchases, you do not have to send us a claim, but you'll need to follow the instructions on the mail service order form and submit it to the address printed on the form. Please allow up to 14 days for delivery.

Timely Filing

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies
- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, or the timeframe listed above, whichever is greater

We won't provide benefits for claims we receive after the later of these two dates, nor will we provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

Special Notice about Claims Procedure

We'll make every effort to process your claims as quickly as possible. (**Please note:** claims are generally processed in the order they are received.) We'll tell you if this plan won't cover all or part of the claim no later than 30 days after we first receive it. This notice will be in writing. We can extend the time limit by up to 15 days if it's decided that more time is needed due to matters beyond our control. We'll let you know before the 30-day time limit ends if we need more time. If we need more information from you or your provider in order to decide your claim, we'll ask for that information in our notice and allow you or your provider at least 45 days to send us the information. In such cases, the time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information we need, we have 15 days to give you our decision.

If your claim was denied, in whole or in part, our written notice (see "Notices") will include:

- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information we may need to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of our complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter from our medical department stating these reasons. The letter will also include how ongoing care may be covered during the appeal process, as described in "When You Have An Appeal" below.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer or a friend or relative. You must notify us in writing and give us the name, address and telephone number where your appointee can be reached.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in this plan, you may file suit in a state or federal court.

COMPLAINTS AND APPEALS

Please call Customer Service when you have questions about a benefit or coverage decision or the quality or availability of a health care service. Customer Service can quickly and informally correct errors and clarify benefits. There may be times when Customer Service will ask you to submit your complaint for review through the formal appeals process outlined below.

We suggest that you call your provider of care when you have questions about the health care services they provide.

If you need an interpreter to help with oral translation services, please call us. Customer Service will be able to guide you through the service.

When You Do Not Agree With A Payment Or Benefit Decision

If a payment or benefits were denied in whole or in part, and you disagree with that decision, you have the right to ask the plan to review that adverse benefit determination through a formal, internal appeals process.

This Plan's appeals process will comply with any new requirements as necessary under state and federal laws and regulations.

What is an adverse benefit determination?

An adverse benefit determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in this plan, rescission of coverage, and including, with respect to this plan, a denial reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medical necessary or appropriate.

When You Have An Appeal

After you find out about an adverse benefit decision, you can ask for an internal appeal. Your Plan includes two levels of internal appeals.

Your Level I internal appeal will be reviewed by people who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be done by a provider. They will review all of the information about your appeal and will give you a written decision. If you are not satisfied with the decision, you may request a Level II appeal.

Your Level II internal appeal will be reviewed by a panel of people who were not involved in the Level I appeal. If your appeal involves medical judgment, a provider will be on the panel. You may participate in the Level II panel meeting in person or by phone. Please contact us for more details about this process.

Once the Level II review is complete, you will receive a written decision.

If you are not satisfied with the outcome of an internal appeal (Level I and Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

Who may file an internal appeal?

You may file an appeal for yourself. You can also appoint someone to do it for you. This can be your doctor or provider. To appoint a representative, you must sign an authorization form and send it to us. The address and fax number are listed on the back cover. This release gives us your approval for this person to appeal on your behalf and allows our release of information, if any, to them. If you appoint someone else to act for you, that person can do any of the tasks listed below that you would need to do.

Please call us for an Authorization For Release form. You can also obtain a copy of this form on our Web site at **www.premera.com/wy**.

How do I file an internal appeal?

You may file an appeal by calling Customer Service or by writing to us at the address listed on the back cover of this booklet. We must receive your appeal request as follows:

- For a Level I internal appeal, within 180 calendar days of the date you were notified of the adverse benefit determination.
- For a Level II internal appeal, within 60 calendar days of the date you were notified of the Level I determination. If you are in the hospital or away from home hospitalized or traveling, or for other reasonable cause beyond your control, we will extend this timeline up to 180 calendar days to allow you to get medical records or other documents you want us to look at.

You may submit your written appeal request to the address or fax number on the back cover of this booklet.

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed in the back of this benefit booklet. You can also get a description of the appeals process by visiting our website at **www.premera.com/wy.**

We will confirm in writing that we have your request within 72 hours.

What if my situation is clinically urgent?

If your provider believes that situation is urgent under law, we will expedite your appeal for example:

- Your doctor thinks a delay may put your life or health in serious jeopardy or would subject you to pain that you cannot tolerate
- The appeal is related to inpatient or emergency services and you are still in the emergency room or in the ambulance

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements. Please call Customer Service if you want to expedite your appeal. The number is listed on the back cover of this booklet.

If your situation is clinically urgent, you may also request an expedited external review at the same time you request an expedited internal appeal.

Can I provide more information for my appeal?

You may supply additional information to support your appeal at the time you file an appeal or at a later date. Mail or fax the information to the address and fax number listed on the back cover of this booklet. Please give us this information as soon as you can.

Can I request copies of information relevant to my appeal?

We will also send you any new or additional information we considered, relied upon or generated in connection to your appeal. We will send it as soon as possible and free of charge. You will have the opportunity to review this information and respond before the final decision on your appeal is made.

What happens next?

The adverse benefit determination will be reviewed and you will receive a written decision within the time limits below:

- Expedited appeals: as soon as possible, but no later than 72 hours after we received your request. You will be notified of the decision by phone, fax or email and will be followed by a written decision.
- Adverse benefit determinations made prior to you receiving services: 15 days of the date we received your request.
- All other appeals: within 30 days of the date we received your request.

We will send you a notice of our decision (see "Notices" later in this booklet) and the reasons for it. If the initial decision is upheld, we will tell you about your right to a Level II internal appeal or to an external review at the end of the internal appeals process**.** You can also go to the next appeal step if we do not comply with the rules above when we handle your appeal.

Appeals about ongoing care

If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, we will suspend the Plan's denial of benefits during the internal appeal period. The Plan's provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse the denial. If the denial decision is upheld, you must repay the Plan all amounts paid for such services. You will also be responsible for any difference between the allowable charge and the provider's billed charge if the provider is non-network.

When Am I Eligible For External Review?

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

We will send you an external review request form at the end of the internal appeal process to tell you about your rights to an external review. Your written request for an external review must be received no later than 4 months after the date you received the Level II appeal response. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to your request.

You can request an expedited external review when your provider believes that your situation is clinically urgent under law. Please call Customer Service at the number listed on the back cover of this benefit booklet to request an expedited external review. We will tell the IRO that you asked for an external review. The IRO will let you, your authorized representative and/or your attending physician know where more information may be sent directly to the IRO and when the information must be provided.

When the IRO completes the external review

Once the external review is done, the IRO will let you and us know in writing of their decision within the time limits below:

- For expedited external reviews, as soon as possible, but no later than 72 hours after receiving the request. The IRO will notify you and us immediately by phone, e-mail or fax and will follow up with a written decision by mail.
- For all other reviews, within 45 days from the date the IRO gets your request.

What happens next?

The Plan is bound by the decision made by the IRO. If the IRO overturned the internal decision, the plan will implement their decision in a timely manner.

If the IRO upheld the internal decision, there is no further review available under this Plan's appeals

process. However, you may have other you can take under State or Federal law, such a filing a lawsuit.

Other Resources To Help You

If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Blue Cross Customer Service for assistance at the number listed on the back cover of your benefit booklet.

If you need help filing an appeal, you can also contact the Washington Consumer Assistance Program at any time during this process.

Washington Consumer Assistance Program

5000 Capitol Blvd.

Tumwater, WA 98501

1-800-562-6900

E-mail: cap@oic.wa.gov

You can also contact the Employee Benefits Security Administration of the U.S. Department of Labor. Their phone number is 1-866-444-EBSA (3272).

Additional Information about Your Coverage

Your benefit booklet provides you with detailed information about this plan's benefits, limitations and exclusions, how to obtain care and how to appeal our decisions.

You may also ask for the following information:

- Your right to seek and pay for care outside of this plan.
- How we pay providers.
- How providers' payment methods help promote good patient care.
- A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations.
- How to file a complaint and a copy of our process for resolving complaints.
- How to access specialists.
- Obtaining preauthorization when needed.
- Accreditation by national managed care organizations.
- Use of the health employer data information set (HEDIS) to track performance.

If you want to receive this information, please call Customer Service. Our phone numbers are shown inside the front cover of this booklet.

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how Weyerhaeuser's contract with us and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

Conformity with the Law

Weyerhaeuser's contract is issued and delivered in the state of Washington and is governed by the laws of the state of Washington, except to the extent pre-empted by federal law. If any provision of Weyerhaeuser's contract or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Member Cooperation

You're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.

Entire Contract

The entire contract between Weyerhaeuser and us consists of all of the following:

- The contract face page and Standard Provisions
- This benefit booklet
- The Funding Arrangement Agreement between Weyerhaeuser and us
- All attachments, endorsements and riders included or issued hereafter

No agent or representative of Premera Blue Cross or any other entity is authorized to make any changes, additions or deletions to the Weyerhaeuser contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done over the signature of an officer of Premera Blue Cross.

Evidence of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you or on your behalf by your health care providers. No benefits will be available if the proof isn't provided or acceptable to us.

Weyerhaeuser and You

Weyerhaeuser is your representative for all purposes under this plan and not the representative of Premera Blue Cross. Any action taken by Weyerhaeuser will be binding on you.

Weyerhaeuser or its applicable delegate has sole and absolute discretion and authority to interpret the terms of Weyerhaeuser employee benefit plans, resolve any ambiguities and inconsistencies in the plan, and make all decisions about eligibility for and entitlement to benefits. When applicable, Weyerhaeuser may defer this discretion and authority to Premera Blue Cross.

Intentionally False or Misleading Statements

If this plan's benefits are paid in error due to any intentionally false or misleading statements, we'll be entitled to recover these amounts. Please see the "Right Of Recovery" provision later in this section.

And, if you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, at our option:

- Deny the member's claim
- Reduce the amount of benefits provided for the member's claim
- Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all)

Finally, statements that are intentionally false or misleading on any group form required by us, that affect the acceptability of the Group or the risks to be assumed by us, may cause the Group Contract for this plan to be rescinded.

Please note: We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Notice of Information Use And Disclosure

We may collect, use, or disclose certain information about you. According to the Health Insurance Portability and Accountability Act (HIPAA), this protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for underwriting or enrollment purposes.)
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our Administrative Services contract with Weyerhaeuser

This information may also be collected, used or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our Customer Service department and ask a representative to mail a request form to you.

Notice of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which the plan provides benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are or may be entitled to recover compensation
- The name of any other group or individual insurance plans that cover you

Notices

Any notice we're required to submit will be considered to be delivered if it's mailed to the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you are required to submit notice to us, it will be considered delivered on the postmark date, or if not postmarked, the date we receive it.

Right of Recovery

On behalf of plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if the contract for this plan is rescinded as described in "Intentionally False Or Misleading Statements," we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, the plan won't honor any

attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan.

At our option only we have the right to direct the benefits of this plan to:

- The subscriber
- A provider
- The member
- Another health insurance carrier
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies the plan's obligation as to payment of benefits.

Venue

All suits or legal proceedings brought against us, the plan, or the Group by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date the rights or benefits claimed under this plan were denied in writing, or of the completion date of the independent review process if applicable; and
- In the state of Washington or the state where you reside or are employed.

All suits or legal or arbitration proceedings brought by the plan will be filed within the appropriate statutory period of limitation, and you agree that venue, at the plan's option, will be in King County, the state of Washington.

ERISA PLAN DESCRIPTION

The following information has been provided by Weyerhaeuser to meet ERISA requirements for the summary plan description.

When used in this section, the term "ERISA plan" refers to Weyerhaeuser's employee welfare benefit plan. The "ERISA plan administrator" is Weyerhaeuser. Premera Blue Cross is **not** the ERISA plan administrator.

Weyerhaeuser has an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the "ERISA plan" in this section. The Premera Blue Cross plan described in this booklet is part of the ERISA plan.

ERISA gives subscribers and dependents the right to a summary describing the ERISA plan. The ERISA plan details below, together with the information contained throughout this benefit booklet, make up the "summary plan description" required by ERISA for that portion of the ERISA plan administered by Premera Blue Cross. This booklet is also a part of the contract between Weyerhaeuser and Premera Blue Cross.

Name Of Plan

Comprehensive Medical Plan, which is a part of the Weyerhaeuser Company Health and Dental Plan

Name and Address of Employer & Plan Sponsor

Weyerhaeuser Company
Attn: Employee Benefits COE
CH 3K33

PO Box 9777

Federal Way, WA 98063-9777

800-833-0030

Subscribers and dependents may receive from the Plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan and, if so, the sponsor's address.

Employer Identification Number "EIN"

91-0470860

Plan Number

577

Type of Plan

Employee welfare benefit plan providing health care coverage

Type of Administration

Third-Party through Premera Blue Cross

Additional Plan Number

608

Name, Address, and Telephone Number of ERISA Plan Administrator

Weyerhaeuser Company
Attn: Employee Benefits COE
CH 3K33

PO Box 9777

Federal Way, WA 98063-9777

800-833-0030

Agent for Service of Legal Process

Weyerhaeuser Company
Law Department

Attn: Chief Labor & Employment Counsel
PO Box 9777
Federal Way, WA 98063-9777

253-924-2345

Service of legal process may also be made on the ERISA plan Administrator.

Eligibility to Participate In The Plan

Employees and their dependents are eligible for the benefits of the plan when they meet the eligibility requirements in this booklet, are enrolled with Premera Blue Cross as described in this booklet, and all required subscription charges for them are

and continue to be paid as required by Weyerhaeuser's contract with Premera Blue Cross.

Benefits

The benefit booklet tells you the terms and limitations of each benefit of this plan. You may have lower out-of-pocket costs if you use providers that have signed contracts with us. This booklet explains the provider networks, when applicable. It also tells how benefits are affected if members do not use these providers. The benefit sections of this booklet also explain what part of the cost of covered health care that you must pay.

Disqualification, Ineligibility Or Denial, Loss, Forfeiture, or Suspension of any Benefits

This booklet describes circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, reduction, offset or recovery of any benefits for members.

Source of Contributions

The employer and employee share the cost of the subscriber's coverage and the cost of the dependents' coverage. Self-payments are also permitted; please see the "How Do I Continue Coverage?" section in this booklet.

If the contract between us and Weyerhaeuser terminates for any reason, Weyerhaeuser will be liable, up to the limit defined in the contract, for any claims paid on its behalf subsequent to termination.

Funding Medium

Benefits under the plan are self-insured. This means benefit claims are paid directly from Weyerhaeuser's general assets.

Plan Changes and Termination

The "Contract Termination" and "Changes In Coverage" portions of this booklet describe the circumstances when the contract between Weyerhaeuser and Premera Blue Cross may be changed or terminated. Termination of the contract is not the same as termination of Weyerhaeuser's ERISA plan. Weyerhaeuser may choose to continue its ERISA plan through other insurance contracts or arrangements.

However, no rights are vested under the ERISA plan. Weyerhaeuser reserves the right to change or terminate its ERISA plan in whole or in part, at any time, with no liability.

Weyerhaeuser will tell employees if its ERISA plan is changed or terminated. If the ERISA plan were to be terminated, members would have a right to benefits only for covered services received before the ERISA plan's end date.

ERISA Plan Year

The ERISA plan year ends on each December 31st.

WHAT ARE MY RIGHTS UNDER ERISA ?

As participants in an employee welfare benefit plan, subscribers have certain rights and protections. This section of this plan explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. If the ERISA plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA plan's annual financial report, if ERISA requires the ERISA plan to file an annual report. The ERISA plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse/domestic partner or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. Weyerhaeuser has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in the plan to the extent stated in our administrative services contract with Weyerhaeuser. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to

prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that ERISA plan fiduciaries misuse the ERISA plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please Note: Under ERISA, the ERISA plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA plan administrator, you should contact either the:

- Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1111 Third Ave. Suite 860, MIDCOM Tower, Seattle, WA 98101-3212; or
- Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan. We have the discretionary authority to determine the terms used in this plan.

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Allowable Charge

The allowable charge shall mean one of the following:

- **Providers in Washington and Alaska Who Have An Agreement With Us**

  For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

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

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

  For covered services and supplies received outside Washington and Alaska or in Clark County, Washington, allowable charges are determined as stated in the "What Do I Do If I'm Outside Washington And Alaska?" section ("BlueCard® Program And Other Inter-Plan Arrangements").

- **Providers Who Do Not Have Agreements With Us Or Another Blue Cross Blue Shield Licensee**

  The allowable charge for a provider in Washington or Alaska that doesn't have an agreement with us will be no greater than the maximum allowance that we would have allowed if the medically necessary covered services had been furnished by a provider that has an agreement in effect with. The allowable charge for a provider that doesn't have an agreement with the local Blue Cross and/or Blue Shield Licensee will be no greater than the allowance that that Licensee uses for providers that are not in its network.

When you receive services from providers that **do not** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowable charge, and for your normal share of the claims costs (see the "What Are My Benefits?" section for further detail.)

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in Weyerhaeuser's Administrative Services Agreement with us.

- **Emergency Services**

  Consistent with the requirements of the Affordable Care Act, the allowable charge will be the greatest of the following amounts:

  - The median amount that network providers have agreed to accept for the same services
  - The amount Medicare would allow for the same services
  - The amount calculated by the same method the plan uses to determine payment to non-network providers

  In addition to your deductible, copayments and coinsurance, you will be responsible for charges received from non-network providers above the allowable charge.

  If you have questions about this information, please call us at the number listed on your ID card.

Ambulatory Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Benefit Advisory

A determination by Care Management usually before the service occurs, that the service meets medical necessity criteria and that the member's plan has this type of benefit available. It is not a guarantee of payment. Services are subject to eligibility and benefits at the time of service.

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Chemical Dependency

An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It's 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.
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued.
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted.

Clinical Trials

Treatment that is part of a scientific study of therapy or intervention in the treatment of a disease, syndrome or condition being conducted at phases 1, 2, 3 or 4 level in a national clinical trial sponsored by a national body; for example, the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

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

A "clinical trial" does not include expenses for:

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

You must be enrolled in the trial at the time of treatment for which coverage is requested. We encourage you or your provider to call customer service to determine coverage before you enroll in the clinical trial. We can help you verify that the clinical trial is a qualified clinical trial. You may also be assigned a nurse case manager to work with you and your provider. See "Case Management" for details.

Complication of Pregnancy

A condition which falls into one of the 3 categories listed below that requires covered, medically necessary services which are provided in addition to, and greater than, those usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition.

- Diseases of the mother which are not caused by pregnancy, but which coexist with and are adversely affected by pregnancy
- Maternal conditions caused by the pregnancy which make its treatment more difficult. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix requiring treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma uterine rupture before onset or during labor
  - Ante- or postpartum hemorrhage requiring medical/surgical treatment
  - Placental conditions which require surgical intervention
  - Preterm labor and monitoring
  - Toxemia
  - Gestational diabetes
  - Hyperemesis gravidarum
  - Spontaneous miscarriage or missed abortion
- Fetal conditions requiring in utero surgical intervention

Congenital Anomaly Of A Dependent Child

A marked difference from the normal structure of an infant's body part, that is present from birth and manifests during infancy.

Cost-Share

The member's share of the allowable charge for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See "What Are My Benefits" to find out what your cost-share is.

Custodial Care

Any portion of a service, procedure or supply that is provided primarily:

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel

Effective Date

The date when your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

Employee Service Center (ESC)

Weyerhaeuser Employee Service Center Representatives handle your eligibility and enrollment questions and requests.

Emergency Care

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency care, hospitalization, maternity and newborn care, mental health and chemical dependency services, including behavioral health treatment, prescription drugs, rehabilitative and Habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by us:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet

the standards set in the definition of "Clinical Trials" above in this section will not be deemed experimental or investigational.

- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross and Blue Shield Association Technical Evaluation Center (TEC).

Group

Weyerhaeuser Company is the Group under this plan and is a party to the Group Contract. Weyerhaeuser is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees.

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians.
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A “hospital” will never be an institution that’s run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition or pregnancy.

Injury

Physical harm caused by a sudden event at a specific time and place. It’s independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It’s of no use in the absence of illness or injury.

Medical Emergency

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medical Facility (also called “Facility”)

A hospital, skilled nursing facility, state-approved chemical dependency treatment program or hospice.

Medically Necessary

Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or 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 patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Member (also called “You” and “Your”)

A person covered under this plan as a subscriber or dependent.

Network Provider

A provider that is in one of the networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Non-Network Provider

A provider that is not in one of the provider networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum), including voluntary termination of pregnancy, or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Outpatient

Treatment received in a setting other than an inpatient in a medical facility.

Participating Pharmacy (Participating Retail Mail Service or Specialty Pharmacy)

A licensed pharmacy which contracts with us or our Pharmacy Benefits Administrator to provide Prescription Drug benefits.

Pharmacy Benefits Administrator

An entity that contracts with us to administer Prescription Drug benefits under this plan.

Physician

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.).

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.) licensed in Washington state

Plan (also called “This Plan”)

The benefits, terms and limitations set forth in the contract between us and Weyerhaeuser, of which this booklet is a part.

Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: “Caution: Federal law prohibits dispensing without a prescription.”

Benefits available under this plan will be provided for “off-label” use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
  - The American Hospital Formulary Service-Drug Information
  - The American Medical Association Drug Evaluation
  - The United States Pharmacopoeia-Drug Information
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts).
- The Federal Secretary of Health and Human Services

“Off-label use” means the prescribed use of a drug that’s other than that stated in its FDA-approved labeling.

Benefits are not available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Provider

A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment. Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

Psychiatric Condition

A condition listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse.

Routine Hearing Exam

A routine hearing exam is an exam that is performed in the absence of a change or suspected change in the member's hearing.

Skilled Care

Care that's ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Subscriber

An enrolled employee of Weyerhaeuser. Coverage under this plan is established in the subscriber's name.

Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have 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.

We, Us and Our

Means Premera Blue Cross.

APPENDIX

Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from Weyerhaeuser, but you are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, dial 877.KIDS.NOW or access the website: www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Weyerhaeuser is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in a Weyerhaeuser-sponsored plan. **To be eligible for this special enrollment opportunity you must request coverage within 60 days of being determined eligible for premium assistance**.

If you are living in one of the following states, you may be eligible for assistance paying your Weyerhaeuser-sponsored plan premiums. The following list of states is current as of July 31, 2012:

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	**FLORIDA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone: 907-269-6529	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
ARIZONA – CHIP	**GEORGIA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone: 602-417-5437	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 800-383-4278

IOWA – Medicaid	**NEVADA –** Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 800-992-0900
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 800-792-4884	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	
Website: http://chfs.ky.gov/dms/default.htm Phone: 800-635-2570	
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK –** Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**UTAH** – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://health.utah.gov/upp Phone: 866-435-7414
OKLAHOMA – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 877-314-5678	Medicaid Phone: 800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 800-562-3022 ext. 15473

RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	**WYOMING** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531
TEXAS – Medicaid	
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	

To see if any more states have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa

1-866-444-EBSA (3272) .....

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

877-267-2323

Weyerhaeuser

Where to send claims

MAIL YOUR CLAIMS TO:
Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

MAIL PRESCRIPTION DRUG CLAIMS TO:
Express Scripts
PO Box 14713
Lexington, KY 40512

CONTACT THE PHARMACY BENEFIT ADMINISTRATOR AT:
800-391-9701
www.express-scripts.com

Complaints and Appeals

Premera Blue Cross
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111-9202
Fax: 425-918-5592

www.premera.com/wy
800-995-2420

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