Regence

AWC EMPLOYEE BENEFIT TRUST

AWC HealthFirst® 250 Plan

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Effective January 1, 2025

Your Rights and Protections Against Surprise Medical Bills and Balance Billing in Washington state

Effective January 1, 2025

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. These costs are called cost-sharing. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you take an ambulance ride, have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or if you ask, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, providers, behavioral health emergency services providers and ground ambulance providers must tell you which provider networks they participate in on their website or if you ask.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes ground or air ambulance rides, and care you receive in a hospital or in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals, emergency behavioral health services providers, and ground or air ambulance providers, can **never** require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are **never** required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (preauthorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington state Office of the Insurance Commissioner at their website or by calling 1-800-562-6900.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit the Washington state Office of the Insurance Commissioner's website for more information about your rights under Washington state law.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę́', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi balloojima to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

Introduction

Welcome to participation in the AWC HealthFirst 250 Plan ("Plan"), a self-funded group health plan provided for You by the Association of Washington Cities Employee Benefit Trust ("AWC Trust"), through which Your employer has made arrangements for its eligible employees to participate. Regence BlueShield ("Regence") has been chosen to administer claims for Your group health plan. The AWC Trust is the Plan Sponsor.

PLAN SPONSOR PAID BENEFITS

Your Plan is a Plan Sponsor-paid benefits plan administered by Regence BlueShield (usually referred to as the "Claims Administrator" in this Booklet). This means that the Plan Sponsor, not Regence BlueShield, pays for Your covered medical services and supplies. Your claims will be paid only after the Plan Sponsor provides Regence BlueShield with the funds to pay Your benefits and pay all other charges due under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

The following pages are the Booklet, the written description of the terms and benefits of coverage available under the Plan. This Booklet is effective January 1, 2025, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueShield and makes it void.

Keep in mind that references to "You" and "Your" refer to both the Participant (employee) and Beneficiaries (family members of the employee) (except that in the Eligibility and Enrollment, When Coverage Ends, and COBRA Continuation of Coverage sections, where applicable, the terms "You" and "Your" mean the Participant only). The term "Claimant" means a Participant or a Beneficiary. The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions section or where they are first used and are designated by the first letter being capitalized.

You, through the enrollment form signed by the Participant, and as a beneficiary of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Booklet.

Using Your AWC HealthFirst 250 Booklet

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES

You control Your out-of-pocket expenses by choosing Your Provider under three choices called: "Category 1," "Category 2" and "Category 3."

- **Category 1.** You see a preferred Provider. Your out-of-pocket expenses will be lower when choosing a preferred Provider and You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 2.** You see a participating Provider. Choosing this category means Your out-of-pocket expenses will generally be higher than for Category 1 because larger discounts with preferred Providers may be negotiated. You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 3.** You see a Provider that does not have a participating contract with the Claims Administrator. Choosing this category means You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing.

For each benefit, this Booklet indicates the Provider You may choose and Your payment amount. Definitions of each Provider type are in the Definitions section. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF PARTICIPATION

Your Plan offers You access to valuable services. These include discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. Register at **awctrust.org** for Your

Health Central account to access Trust benefits information, Your Health Assessment, and personalized health news.

You also have access to the Claims Administrator's website and mobile application to help You navigate Your way through health care decisions. For access, You just set up Your free account once and it is always up to You whether to participate. These services are voluntary, not insurance and are offered in addition to the benefits in Your Booklet. Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of the Booklet.

- **Go to regence.com or the Claims Administrator's mobile application.** You can use the Claims Administrator's secure applications to:

  - view recent claims, benefits and coverage;
  - find a contracting Provider or identify Participating Pharmacies;
  - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
  - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
  - learn about prescriptions for various Illnesses;
  - compare medications based upon performance and cost and get assistance in switching to less costly, equally effective alternative medications, if You wish; and
  - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. The Claims Administrator has contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*Note that if You choose to access these discounts, You may receive savings on an item or service that is covered by Your health plan, that also may create savings or administrative fees for the Claims Administrator. Any such discounts or coupons are complements to the group health plan, but are not insurance.

CONTACT INFORMATION

- **Call Customer Service:** 1 (800) 752-9985 (TTY: 711) if You have questions, would like to learn more about Your Plan, have not received or have lost Your Plan identification card, or would like to request written or electronic information regarding any other plan that the Claims Administrator offers. Phone lines are open Monday-Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.
- **Visit the Claims Administrator's website, regence.com,** to submit a claim online or chat live with a Customer Service representative, or to access a list of contracted health care benefit managers acting on the Claims Administrator's behalf in the utilization of health care services, which can be found at **regence.com/member/members/member-notices**.
- **For assistance in a language other than English,** call the Customer Service telephone number.
- **Call Case Management:** 1 (866) 543-5765 to request that a case manager be assigned to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information refer to the Medical Benefits section.
- **BlueCard® Program.** Call Customer Service to learn how to access care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.
- **Medical Policy.** Regence medical policy and clinical criteria can be found at **http://blue.regence.com/trgmedpol**.

Table of Contents

Understanding Your Benefits

In this section, You will find information to help You understand what is meant by Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. This section defines cost-sharing elements, but You will need to refer to the benefit section(s) to see exactly how they are applied.

CONTACT INFORMATION

Call Customer Service at 1 (800) 752-9985 (TTY: 711) or visit the Claims Administrator's website at **regence.com**.

MAXIMUM BENEFITS

Some benefits may have a specific Maximum Benefit. Benefits are covered until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount, or specified time period) has been reached. Refer to the benefit sections to determine if a Covered Service has a specific Maximum Benefit.

Amounts You pay toward Your Deductible also apply to any specified Maximum Benefit.

You will be responsible for the total billed charges for benefits in excess of any Maximum Benefits, and for charges for any other services or supplies not covered by this Plan, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES

The Deductible is the amount You are required to pay for Covered Services before the Plan begins to pay benefits for Covered Services in a Calendar Year. Allowed charges and eligible expenses are applied towards the Calendar Year Deductible. Calendar Year Deductibles are specified in the Medical Benefits section.

The Calendar Year Deductible is available on a per Claimant and per Family basis. For the Family Calendar Year Deductible, one Claimant will not contribute more than the individual Deductible amount.

The Plan does not pay for services applied towards any Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible. Refer to the Medical Benefits section to see if a particular service is subject to the Deductible.

Certain Covered Services for Preventive Care are not subject to the Deductible, and the Plan pays benefits for these services even though You have not satisfied Your Deductible.

In addition, if Covered Services are incurred during the last three months of a Calendar Year and are applied toward the Deductible for that year, then any amount for Covered Services applied toward such Deductible during the last three months will be carried forward and applied toward the Deductible for the following year. If the amount applied toward the Deductible for a Claimant in the last three months of a Calendar Year is greater than the Claimant's individual Deductible in the following year (because the following year's Deductible is lower), then the Claimant's individual Deductible for that following year is met. Further, the full amount applied toward the Claimant's individual Deductible in the last three months of the previous year is applied to the Family Deductible for the following year.

COPAYMENTS

A Copayment is a flat dollar amount that You generally pay directly to the Provider at the time You receive a specified service. Copayments are not applied toward the Deductible.

Refer to the benefit section(s) to understand what Copayments You are responsible for.

COINSURANCE

Once You have satisfied any applicable Deductible and Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. The percentage You pay

varies, depending on the service or supply You received. Refer to the benefits sections for Coinsurance amounts You pay.

The Plan does not reimburse Providers for charges above the Allowed Amount. A preferred or participating Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount if You choose Category 1 or Category 2. Nonparticipating Providers may bill You for any balances over the Plan payment level in addition to any Deductible, Copayment and/or Coinsurance amount (referred to as balance billing) if You choose Category 3.

BALANCE BILLING

Balance billing occurs when You are billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services provided to You by a nonparticipating Provider when the nonparticipating Provider's billed amount is not fully reimbursed by the Plan. Any services not mentioned in this Balance Billing provision are subject to balance billing. You will not be balance billed by a nonparticipating Provider for ground or air ambulance services, emergency services or for certain non-emergency surgical or ancillary services provided by a nonparticipating Provider at a preferred or participating Hospital or Ambulatory Surgical Center. Non-emergency surgical or ancillary services include anesthesiology, pathology, radiology, laboratory, hospitalist, or surgical services. Any amounts You pay for ground or air ambulance services, emergency services or for non-emergency surgical or ancillary services will count toward Your Deductible and Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You have to pay for Covered Services in a Calendar Year. The Out-of-Pocket Maximum is met by payments of Deductible, Copayment and/or Coinsurance as indicated in the Medical Benefits and Prescription Medications sections. Once the Out-of-Pocket Maximum is reached, benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. Calendar Year Out-of-Pocket Maximums are specified in the Medical Benefits section.

The Calendar Year Out-of-Pocket Maximum is available on a per Claimant and a per Family basis. For the Family Calendar Year Out-of-Pocket Maximum amount, one Claimant will not contribute more than the individual Out-of-Pocket Maximum amount.

Amounts You pay for non-Covered Services and amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. For additional information on how Prescription Medications apply to Your Out-of-Pocket Maximum, refer to the Prescription Medications Section. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

HOW CALENDAR YEAR BENEFITS RENEW

Many provisions of the Plan (for example, Deductibles, Out-of-Pocket Maximum, and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits of the Plan may have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year. Those exceptions are noted in the benefits sections.

Medical Benefits

This section explains how Your Plan pays for Covered Services.

Referrals are not required and nothing contained in this Booklet is designed to restrict Your choice of Provider for care or treatment of an Illness or Injury.

Some Covered Services may require a prescription or preauthorization. Contracted Providers may be required to obtain preauthorization from the Claims Administrator before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization in advance from the Claims Administrator and the service is determined to be not covered. Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator prior to providing services. You may be responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services. A complete list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Claims Administrator's website at: **regence.com/web/regence_provider/pre-authorization** or by calling 1 (800) 752-9985.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Benefits for Gender Affirming Treatment are covered the same as any other Covered Services (to the extent such services are permitted under applicable law), regardless of an individual's sex assigned at birth, gender identity or expression. All covered benefits are subject to the limitations, exclusions and provisions of this Plan. A Health Intervention may be medically indicated or otherwise Medically Necessary, yet not be a Covered Service. In some cases, benefits or coverage may be limited to a less costly and Medically Necessary alternative item. See the Definitions section for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

If benefits change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

Reimbursement may be available for new medical supplies, equipment, and devices You purchase from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. New medical supplies, equipment, and devices, such as a breast pump or wheelchair, purchased through an approved Commercial Seller are covered at the Category 1 level, with reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access an approved Commercial Seller and reimbursable new retail medical supplies, equipment, and devices, visit the Claims Administrator's website or contact Customer Service.

If You choose to access new medical supplies, equipment, and devices through the Claims Administrator's website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious Illness or Injury that have the potential for continuing major or complex care. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

Covered Services may be either preventive or diagnostic. "Preventive" care is intended to prevent an Illness, Injury or to detect problems before symptoms are noticed. "Diagnostic" care treats, investigates or diagnoses a condition by evaluating new symptoms, following up on abnormal test results or monitoring existing problems.

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Booklet will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered elsewhere in the Medical Benefits Section. You may want to ask Your Provider why a Covered Service is ordered or requested.

CALENDAR YEAR DEDUCTIBLES

Per Claimant: $250
Per Family: $750

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Per Claimant: $3,000
Per Family: $6,000

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic, or other public health emergency. In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a complete list of services covered under this benefit, including information about how to access an approved Commercial Seller, obtaining a breast pump and instructions for obtaining reimbursement for a new breast pump purchased from an approved Commercial Seller, retailer, or other entity that is not a Provider, visit the Claims Administrator's website or contact Customer Service.

If You choose to access new medical supplies, equipment, and devices through the Claims Administrator's website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

NOTE: Services that are billed as preventive and meet these criteria will be covered under this Preventive Care and Immunizations benefit, however, all Food and Drug Administration (FDA) approved contraceptive drugs, devices, products and services are covered under the Reproductive Health Care Services benefit or the Prescription Medication Benefits. Other Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered elsewhere in the Medical Benefits Section.

Preventive Care

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Preventive care services provided by a professional Provider, facility or Retail Clinic are covered, such as:

- routine physical examinations, well-baby care, women's care (including screening for gestational diabetes), and health screenings including screening for obesity in adults with a body mass index (BMI) of 30 kg/m2 or higher;
- intensive multicomponent behavioral interventions for weight management;
- Provider counseling and prescribed medications for tobacco use cessation;
- preventive mammography services, including tomosynthesis (3D);
- depression screening for all adults, including screening for maternal depression; and
- breastfeeding support and one new non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from a Provider (including a Durable Medical Equipment supplier) or a comparable new breast pump obtained from an approved Commercial Seller, even though that seller is not a Provider.

Prostate cancer screening is covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal exams and prostate-specific antigen (PSA) tests.

Immunizations – Adult

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Immunizations for adults are covered according to, and as recommended by, the USPSTF and the CDC.

Immunizations – Childhood

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay any balance of billed charges.

Immunizations for children (through 18 years of age) are covered, according to, and as recommended by, the USPSTF and the CDC.

Immunizations – Travel

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Immunizations are covered for the purpose of travel, occupation, or residency in a foreign country.

OFFICE OR URGENT CARE CENTER VISITS – ILLNESS OR INJURY

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible,* You pay 10% of the Allowed Amount. *Deductible waived for the first four office or urgent care center visits per Claimant per Calendar Year. Limit is shared with outpatient Mental Health and Substance Use Disorder visits.	**Payment:** After Deductible,* You pay 30% of the Allowed Amount. *Deductible waived for the first four office or urgent care center visits per Claimant per Calendar Year. Limit is shared with outpatient Mental Health and Substance Use Disorder visits.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Office visits (including home, Retail Clinic or Hospital outpatient department) and urgent care center visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care center that are specifically covered elsewhere in the Medical Benefits section, including, but not limited to, separate Facility Fees or outpatient radiology and laboratory services billed in conjunction with the visit.

PROFESSIONAL SERVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and may be balance billed.

Professional services and supplies include the following:

Diagnostic Procedures

Services for diagnostic procedures including services to diagnose infertility, cardiovascular testing, pulmonary function studies, stress tests, sleep studies and neurology/neuromuscular procedures are covered.

Medical Services and Supplies

Professional services, second opinions and supplies are covered, including the services of a Provider whose opinion or advice is requested by the attending Provider.

Services and supplies also include:

- treatment of a congenital anomaly;
- Virtual Care service Facility Fees;
- foot care associated with diabetes; and
- Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Additionally, some general medical services and supplies, such as compression stockings, active wound care supplies, and sterile gloves, are covered when Medically Necessary. Reimbursement for covered medical supplies may be available when these new supplies are obtained from an approved Commercial Seller, even though that seller is not a Provider. Eligible new general medical supplies purchased through an approved Commercial Seller are covered at the Category 1 level, with Your reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access an approved Commercial Seller and reimbursable new general medical supplies, visit the Claims Administrator's website or contact Customer Service.

Professional Inpatient
Professional inpatient visits (or comparable in-network mobile visits when a referral is made by Your Provider) for Illness or Injury are covered. If You are admitted as an inpatient to a Category 1 Hospital and the admitting Practitioner also is Category 1, then benefits for associated Covered Services provided during the admission by a Category 2 or 3 Hospital-based Practitioner (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) are eligible for coverage at the Category 1 level. If services were not covered at the Category 1 level, contact Customer Service for an adjustment to Your claims.

Radiology and Laboratory
Diagnostic services, including complex imaging, for treatment of Illness or Injury are covered. This includes Medically Necessary genetic testing, prostate screenings, and colorectal laboratory tests not covered in the Preventive Care and Immunizations benefit. Diagnostic and supplemental breast examinations (including mammography) are also covered and services received from a preferred or participating Provider are not subject to any cost-sharing.

"Complex imaging" means:

- bone density screening;
- computerized axial tomography (CT or CAT) scan;
- magnetic resonance angiogram (MRA);
- magnetic resonance imaging (MRI);
- positron emission tomography (PET); and
- single photon emission computerized tomography (SPECT).

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

Surgical Services
Surgical services and supplies including cochlear implants and the services of a surgeon, an assistant surgeon and an anesthesiologist are covered. Medical colonoscopies are covered. Preventive colonoscopies and colorectal cancer examinations are covered under the Preventive Care and Immunizations benefit.

Therapeutic Injections
Therapeutic injections, administration, and related supplies, including clotting factor products, are covered when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications section.

ACUPUNCTURE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: 20 visits per Claimant per Calendar Year.		

Acupuncture visits are covered. Acupuncture visits apply to the Maximum Benefit limit for these services, including acupuncture visits that are applied toward any Deductible. (For acupuncture to treat Substance Use Disorder Conditions, refer to the Substance Use Disorder Services benefit.)

AMBULANCE SERVICES

Category: All
Provider: All
Payment: After Deductible, You pay 20% of the Allowed Amount.

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger Your health and the transportation is not for personal or convenience purposes. Covered Services include licensed ground and air ambulance Providers.

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group and Your identification numbers.

AMBULATORY SURGICAL CENTER

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Outpatient services and supplies are covered, including professional services and facility charges, for an Ambulatory Surgical Center for Illness and Injury.

APPROVED CLINICAL TRIALS

If You are accepted as a trial participant in an Approved Clinical Trial, Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits and Prescription Medications sections. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Additional specified limits are as further defined.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other Life-threatening Condition and that is a study or investigation:

- approved or funded by one or more of:
  - the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid, or a cooperative group or center of any of those entities, or a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
  - a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
  - the VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or
- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

Life-threatening Condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Patient Costs means items and services that typically are Covered Services for a Claimant not enrolled in a clinical trial, but do not include:

- an Investigational item, device, or service that is the subject of the Approved Clinical Trial;
- items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

BARIATRIC SERVICES

Office Visits

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Bariatric Surgery

Category 1	Category 2	Category 3
Provider: Preferred (Blue Distinction Centers)	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** Not covered.	**Payment:** Not covered.
Limit: $35,000 per Claimant per Lifetime. Surgeries with complication diagnosis codes not subject to dollar limit.		

Bariatric surgery to treat obesity is covered only after the Claims Administrator evaluates and approves that the surgery meets its published medical policy. To be covered, the approved bariatric surgery must be received from a Blue Distinction Centers (BDC) facility or a Blue Distinction Centers+ (BDC+) facility. To identify a BDC or BDC+ facility, contact the Claims Administrator's Customer Service.

Coverage does not include weight loss medications, treatment for complications, or revisions and reversals of bariatric surgery, unless the previous bariatric surgery was approved by a United States medical insurance plan and the bariatric surgery was performed in the United States. If a covered complication, revision or reversal is received, the procedure will be covered the same as any other Illness or Injury and the procedure will not accrue to the Maximum Benefit limit on these services.

BLOOD BANK

Category: All
Provider: All
Payment: After Deductible, You pay 20% of the Allowed Amount.

Services and supplies of a blood bank are covered, excluding storage costs.

DENTAL HOSPITALIZATION

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital, if hospitalization is necessary to safeguard Your health because treatment in a dental office would be neither safe nor effective. Benefits are not available for services received in a dentist's office.

DETOXIFICATION

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount and You pay any balance of billed charges.

Medically Necessary detoxification services are covered.

DIABETIC EDUCATION

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies for diabetic self-management training and education are covered. Diabetic nutritional counseling and nutritional therapy are covered under the Nutritional Counseling benefit.

DIALYSIS

Services and supplies for outpatient and home dialysis are covered as described below. Dialysis received while inpatient is covered elsewhere in the Medical Benefits Section, such as the Hospital Care benefit.

Outpatient Initial Treatment Period

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Outpatient limit: three months per Claimant (42 treatments of hemodialysis or 30 days peritoneal dialysis) for the initial treatment period		

Hemodialysis, peritoneal dialysis and hemofiltration services, supplies, medications, labs and Facility Fees are covered during the initial treatment period when Your Physician prescribes outpatient dialysis. You should first contact the Claims Administrator to begin Case Management. A case manager will help You enroll in the Supplemental Kidney Dialysis Program. The "Supplemental Kidney Dialysis Program" is a supplemental program available to Claimants following the initial treatment period.

The "initial treatment period" will be three months of hemodialysis (42 treatments) or peritoneal dialysis (30 days). Once the initial treatment period limit is reached, outpatient dialysis may be covered according to the Outpatient Supplemental Treatment Period benefit below. If more than three months of treatment is necessary in the initial treatment period, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. Dialysis treatments apply to the Maximum Benefit limit for these services, including dialysis treatments that are applied toward any Deductible.

Services that are rendered outside the country are covered, even if You have enrolled in the Supplemental Kidney Dialysis Program.

Outpatient Supplemental Treatment Period

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Plan, the Plan pays 100% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Plan, the Plan pays 100% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** The Plan pays 150% of the Medicare allowed amount at the time of service. If You are not enrolled in Medicare Part B, You pay the balance of billed charges, which will not apply toward the Out-of-Pocket Maximum.

Supplemental treatment is covered for any outpatient dialysis that is required beyond the initial treatment period.

In addition, a Claimant receiving supplemental dialysis is eligible to have Medicare Part B premiums reimbursed as an eligible expense for the duration of the Claimant's dialysis treatment, as long as the Claimant continues to be enrolled in Medicare Part B and continues to be eligible for coverage under this Plan. Proof of payment of the Medicare Part B premium will be required prior to reimbursement.

"Medicare allowed amount" is the amount that a Medicare-contracted Provider agrees to accept as full payment for a Covered Service. This is also referred to as the Provider accepting Medicare assignment.

Case Managed Dialysis and Supplemental Kidney Dialysis Program

Receive one-on-one help and support in the event Your Physician prescribes dialysis. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to enroll in Case Management, call 1 (866) 543-5765.

DURABLE MEDICAL EQUIPMENT

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Durable Medical equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes (such as insulin pumps and continuous glucose monitors,

and their supplies). Applicable sales tax for Durable Medical Equipment and mobility enhancing equipment is also covered.

Reimbursement may also be available for new Durable Medical Equipment when obtained from an approved Commercial Seller, even though this entity is not a Provider. Eligible new Durable Medical Equipment purchased through an approved Commercial Seller is covered at the Category 1 Provider level, with Your reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To find ways to access new Durable Medical Equipment, including how to access an approved Commercial Seller, visit the Claims Administrator's website or contact Customer Service. If You choose to access new Durable Medical Equipment through the Claims Administrator's website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After $75 Copayment per visit and Deductible, You pay 10% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** After $75 Copayment per visit and Deductible, You pay 10% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** After $75 Copayment per visit and Deductible, You pay 10% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations and treatment, routinely available ancillary evaluative services, and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. "Stabilization" means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Claimant from a facility; and 2) in the case of a covered Claimant, who is pregnant, to perform the delivery (including the placenta).

Post-exposure prophylaxis (PEP) medications are covered for the prevention of HIV for people at a high risk of infection after an exposure, as recommended by the CDC. You are not responsible for any cost-sharing for PEP medications dispensed in an emergency room.

Emergency room services do not need to be pre-authorized.

If You are admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. If services were not covered at the Category 1 benefit level, contact Customer Service for an adjustment to Your claims.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: All Other Providers
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** You pay 100% of the billed charges. Your payment will not be applied toward any Deductible or Out-of-Pocket Maximum.

If You fulfill Medical Necessity criteria and receive therapy from a Provider expressly identified by the Claims Administrator as a Centers of Excellence (COE) for that therapy, gene therapies and/or adoptive cellular therapies and associated Medically Necessary Covered Services are covered under this benefit. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from a preferred or participating Provider to be covered at the COE benefit level. Contact Customer Service for a current list of covered gene and cellular therapies and/or to identify a COE.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your Deductible and travel expense limit.
Limit: $7,500 per Claimant per course of treatment, including companion(s), for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered subject to the following specified limits:

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from a preferred or participating Provider;
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Claimant, not to exceed $100 per night for the Claimant and companion(s) combined); and
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Customer Service for further information and guidance.

Coverage does not include meals or expenses outside of transportation and lodging.

GENDER AFFIRMING TREATMENT

The Plan covers Medically Necessary services for Gender Affirming Treatment for adults and children, to the extent such services are permitted under applicable law. Consistent with the Claims Administrator's current medical policies, Covered Services may include, but are not limited to, surgical services (including facility and ancillary charges), prescription drugs, lab, x-ray and other non-surgical services and mental health treatment. These services are subject to the general plan provisions, limitations and exclusions of the Plan. Refer to the Hospital Care, Professional Services, Office Visits, Prescription Medications, and Mental Health Services benefits for specific coverage details.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your Deductible and travel expense limit.
Limit: $2,000 per Claimant per course of treatment, including companion, for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered, for the purpose of receiving Covered Services (including Prescription Medications) not available in the Claimant's state of residence due to a legal restriction, subject to the following specified limits. Travel expenses will not be covered if payment for such expenses is illegal under applicable law.

- coverage is limited to travel expenses for Covered Services associated with Gender Affirming Treatment surgical procedures;
- coverage is limited to the Claimant and up to one companion;
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Claimant, not to exceed $100 per night for the Claimant and companion combined) and;
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class bus fare;
    - commercial coach class train fare; or
    - auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. Documentation of all travel expenses and Covered Services received must be retained and submitted for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

These travel benefits are separate and distinct from any other travel benefits described elsewhere in this Booklet. Coverage does not include meals or expenses outside of transportation and lodging or travel outside of the United States of America.

HEARING EXAMINATIONS (ROUTINE)

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: one routine hearing examination per Claimant per Calendar Year		

Routine hearing examinations apply to the Maximum Benefit limit for these services, including routine hearing examinations that are applied toward any Deductible.

HEARING INSTRUMENTS AND SERVICES

Hearing Instruments

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of billed charges, up to the limit. You are responsible for any remaining balance.	**Payment:** The Plan pays 100% of billed charges, up to the limit. You are responsible for any remaining balance.	**Payment:** The Plan pays 100% of billed charges, up to the limit. You are responsible for any remaining balance.
Limit: The Plan pays up to $3,000 per ear with hearing loss, per Claimant every 36 months.		

Hearing Services

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay any balance of billed charges.

Hearing instruments are covered. "Hearing instrument" means any wearable prosthetic instrument or device (including bone conduction hearing devices) designed for or represented as aiding, improving, compensating for, or correcting defective human hearing and any parts, attachments, or accessories of such an instrument or device, excluding batteries, cords, and assistive listening devices. Cochlear implants and surgical implantation for bone conduction hearing devices and cochlear implants are covered in the Professional Services benefit.

Covered Services also include the following hearing services:

- initial assessment;
- fitting;
- adjustment;
- auditory training; and
- ear molds (as necessary to maintain optimal fit).

Covered Services do not include:

- over-the-counter hearing aids;
- routine hearing examinations;
- hearing assistive technology systems; or
- the cost of batteries or cords.

HOME HEALTH CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount and You pay any balance of billed charges.
Limit: 130 visits per Claimant per Calendar Year		

Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Home health care visits apply to the Maximum Benefit limit for these services, including home health care visits that are applied toward any Deductible.

Durable Medical Equipment associated with home health care is covered under the Durable Medical Equipment benefit.

HOSPICE CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount and You pay any balance of billed charges.
Limit: 14 inpatient or outpatient respite care days per Claimant Lifetime		

Hospice care is covered when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and their family during the final stages of Illness.

Respite care is also covered to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Respite care days apply to the Maximum Benefit limit for these services, including respite care days that are applied toward any Deductible.

Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit.

HOSPITAL CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Inpatient and outpatient services and supplies of a Hospital are covered for Illness and Injury (including Prescription Medications and services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If You are admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level.

If You need significant long-term medical supervision, Hospital confinement may not always be the best environment. The Claims Administrator may approve coverage for alternative care and treatment based on Your medical needs and the recommendation of Your Provider. Case managers will work with Your Physicians and other health care professionals, with Your consent, to ensure You receive cost effective and appropriate care.

INFERTILITY TREATMENT

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: $20,000 per Claimant Lifetime		

Surgical and nonsurgical treatment (including medications received from a Provider to treat infertility) is covered for the correction of infertility. Additionally, assisted reproductive procedures are covered, including:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer; and
- any associated surgery, medications received from a Provider, testing or supplies.

Medications to treat infertility received from a Pharmacy are covered in the Prescription Medications section.

INFUSION THERAPY

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy.

MATERNITY CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions, and Medically Necessary supplies for home birth are covered. Covered Services include Medically Necessary donor human milk from a milk bank for inpatient use. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time, in consultation with the patient.

Certain services such as screening for maternal depression, gestational diabetes, breastfeeding support, supplies and counseling are covered under the Preventive Care benefit.

Surrogacy

Maternity and related medical services received by You while Acting as a Surrogate are not Covered Services, up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. By incurring and making claim for such services, You agree to reimburse the Plan the lesser of the amount described in the preceding sentence and the amount the Plan paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under the Plan).

You must notify the Claims Administrator within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with the Claims Administrator as needed to ensure the Claims Administrator's ability to recover the costs of Covered Services received by You for which the Plan is entitled to reimbursement. To notify the Claims Administrator, or to request additional information on Your

responsibilities related to these notification and cooperation requirements, contact Customer Service. More information is in the Subrogation and Right of Recovery section.

Definitions

The following definition applies to this Maternity Care benefit:

Acting (or Act) as a Surrogate means You agree to become pregnant and to surrender, relinquish or otherwise give up any parental rights to the baby (or babies) produced by that pregnancy to another person or persons who intend to raise the baby (or babies), whether or not You receive payment, the agreement is written and/or the parties to the agreement meet their obligations.

MEDICAL FOODS

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 10% of the Allowed Amount and You pay any balance of billed charges.

Medical foods for inborn errors of metabolism are covered including, but not limited to, formulas for Phenylketonuria (PKU). Medically Necessary elemental formula is covered when a Provider diagnoses and prescribes the formula for a Claimant with eosinophilic gastrointestinal associated disorder. "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

MENTAL HEALTH SERVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible,* You pay 10% of the Allowed Amount. *Deductible waived for the first four outpatient psychotherapy and/or psychiatric office visits per Claimant per Calendar Year. Limit is shared with Substance Use Disorder visits and Office or Urgent Care Center Visits – Illness or Injury.	**Payment:** After Deductible,* You pay 10% of the Allowed Amount. *Deductible waived for the first four outpatient psychotherapy and/or psychiatric office visits per Claimant per Calendar Year. Limit is shared with Substance Use Disorder visits and Office or Urgent Care Center Visits – Illness or Injury.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Mental Health Services are covered for treatment of Mental Health Conditions.

Additionally, applied behavioral analysis (ABA) therapy services are covered for treatment of autism spectrum disorders (ASD) when Claimants seek services from licensed Providers qualified to prescribe and perform ABA therapy services. A diagnosis of ASD/PDD (Pervasive Developmental Disorder) must be made by an appropriate provider (neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or doctoral level psychologist) experienced in the diagnosis and treatment of autism. ABA therapy must be prescribed as appropriate for the patient, and services must be Medically Necessary and meet Regence clinical criteria guidelines.

Refer to the Virtual Care benefit for behavioral health services available through MDLIVE.

Refer to the Value-Added Services and Programs Appendix for information on the Compsych Employee Assistance Program.

Definitions
The following definitions apply to this Mental Health Services benefit:

Mental Health Conditions means mental disorders, including eating disorders, included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, except as otherwise excluded. Mental disorders that accompany an excluded diagnosis are covered.

Mental Health Services means Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is determined to be Medically Necessary).

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs, however services by Physicians or Practitioners in such settings may be covered if they are billed independently and otherwise would be covered.

NEURODEVELOPMENTAL THERAPY

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: 60 professional visits per Claimant per Calendar Year		

Neurodevelopmental therapy services by a Physician or Practitioner are covered. Such services must be to restore or improve function based on developmental delay. Covered Services are limited to physical therapy, occupational therapy and speech therapy. Maintenance services are covered if significant deterioration of the Claimant's condition would result without the service. Neurodevelopmental therapy services apply to the Maximum Benefit limit for these services, including neurodevelopmental therapy services that are applied toward any Deductible. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition. See the Mental Health Services benefit for coverage of neurodevelopmental therapies, such as applied behavioral analysis, that are considered Medically Necessary to treat a Mental Health Condition (including autism).

NEWBORN CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The newborn child must be eligible and enrolled as explained in the Eligibility and Enrollment section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity.

ORTHOTIC DEVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Medically Necessary orthotics used to support, align or correct deformities or to improve the function of moving parts of the body are covered, including, but not limited to, braces, splints, orthopedic appliances, orthotic supplies or apparatuses, and custom molded shoe inserts and orthopedic shoes. The Plan does not cover off-the-shelf shoe inserts, off-the-shelf orthopedic shoes, or Cosmetic items.

The Claims Administrator may elect to provide benefits for a less costly alternative item. Reimbursement may also be available for new orthotic devices when purchased new from an approved Commercial Seller, even though that seller is not a Provider. Eligible new orthotic devices purchased through an approved Commercial Seller are covered at the Category 1 level, with Your reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item.

To learn more about how to access reimbursable new retail orthotic devices, including how to access an approved Commercial Seller, visit the Claims Administrator's website or contact Customer Service. If You choose to access new orthotic devices through the Claims Administrator's website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

PALLIATIVE CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: 30 visits per Claimant per Calendar Year		

Palliative care is covered when a Provider has assessed that a Claimant is in need of palliative services for serious Illness (including remission support), life-limiting Injury or end-of-life care. "Palliative care" means specialized services received from a Provider in a home setting, including:

- home health aide services for activities of daily living and personal care;
- medical services for pain and symptom management;

- psychological and social services such as family counseling, marital counseling and spiritual support visits;
- caregiver support; and
- advance care planning.

Palliative care services may be provided by Physicians, physician assistants, nurses, nurse practitioners, nursing assistants, social workers, behavioral health practitioners, and spiritual care providers.

Palliative care visits apply to the Maximum Benefit limit for these services, including palliative care visits that are applied toward any Deductible. All other Covered Services for a Claimant receiving palliative care remain covered the same as any other Illness or Injury.

PROSTHETIC DEVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, mastectomy bras only for Claimants who have had a mastectomy, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital inpatient care, Hospital outpatient care, or Ambulatory Surgical Center care) in this Medical Benefits section. Repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

REHABILITATION SERVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Inpatient limit: 15 days per Claimant per Calendar Year **Outpatient limit:** 99 visits per Claimant per Calendar Year		

Inpatient and outpatient rehabilitation services and accommodations are covered to restore or improve lost function caused by Illness, Injury or disabling condition. "Rehabilitation services" means physical, occupational, and speech therapy services necessary to help get the body back to normal health or function, and include associated services such as massage when provided as a therapeutic intervention. A prescription is required for outpatient services. Coverage for massage therapy visits is limited to a maximum of 60 minutes per visit. Benefits will be provided for Maintenance Therapy in cases where significant deterioration in the Claimant's condition would result without the services.

Rehabilitation services apply to the Maximum Benefit limit for these services, including rehabilitation services that are applied toward any Deductible. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

A separate program, available at no cost to You, may provide services for acute injuries with assistance from a physical therapist. Such services will not be subject to the limitations and cost-sharing of this benefit. Refer to the Hinge Health program in the Value-Added Services Appendix for more information.

REPRODUCTIVE HEALTH CARE SERVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Termination of pregnancy and related conditions are covered (to the extent such services are permitted under applicable law). The following FDA-approved contraceptive devices, products, and services are also covered when provided by a Physician or Practitioner:

- sterilization surgery (such as tubal ligation and vasectomy) and sterilization implants;
- implantable contraceptive devices, including insertion and removal, such as IUD copper, IUD with progestin, and implantable rods;
- contraceptive shots or injections; and
- diaphragms, and cervical caps.

NOTE: Certain FDA-approved prescription and over-the-counter contraceptive drugs, devices, products and services are covered under the Prescription Medication benefits.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your Deductible and travel expense limit.
Limit: $2,000 per Claimant per occurrence, including companion, for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered, for the purpose of receiving Covered Services (including Prescription Medications) not available in the Claimant's state of residence due to a legal restriction, subject to the following specified limits. Travel expenses will not be covered if payment for such expenses is illegal under applicable law.

- coverage is limited to travel expenses for Covered Services associated with termination of pregnancy;
- coverage is limited to the Claimant and up to one companion;
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Claimant, not to exceed $100 per night for the Claimant and companion combined) and;
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class bus fare;
    - commercial coach class train fare; or
    - auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. Documentation of all travel expenses and Covered Services received must be retained and submitted for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

These travel benefits are separate and distinct from any other travel benefits described elsewhere in this Booklet. Coverage does not include meals or expenses outside of transportation and lodging or travel outside of the United States of America.

SKILLED NURSING FACILITY

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: 90 inpatient days per Claimant per Calendar Year		

Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility services apply to the Maximum Benefit limit for these services, including Skilled Nursing Facility services that are applied toward any Deductible.

SPINAL MANIPULATIONS

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: 20 spinal manipulations per Claimant per Calendar Year		

Chiropractic and osteopathic spinal manipulations are covered. Spinal manipulations apply to the Maximum Benefit limit for these services, including spinal manipulations that are applied toward any Deductible. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits in this Medical Benefits section.

SUBSTANCE USE DISORDER SERVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible,* You pay 10% of the Allowed Amount. *Deductible waived for the first four outpatient psychotherapy and/or psychiatric office visits per Claimant per Calendar Year. Limit is shared with outpatient Mental Health visits and Office or Urgent Care Center Visits – Illness or Injury.	**Payment:** After Deductible,* You pay 10% of the Allowed Amount. *Deductible waived for the first four outpatient psychotherapy and/or psychiatric office visits per Claimant per Calendar Year. Limit is shared with outpatient Mental Health visits and Office or Urgent Care Center Visits – Illness or Injury.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Coverage for treatment of Substance Use Disorder Conditions includes the following:

- acupuncture services (when provided for Substance Use Disorder Conditions, these acupuncture services do not apply toward the overall acupuncture Maximum Benefit); and
- Prescription Medications that are prescribed and dispensed through a substance use disorder treatment facility (such as methadone).

Definitions

The following definitions apply to this Substance Use Disorder Services benefit:

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs, however services by Physicians or Practitioners in such settings may be covered if they are billed independently and otherwise would be covered.

Substance Use Disorder Conditions means substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is Medically Necessary).

For this Substance Use Disorder Services benefit, "medically necessary" or "medical necessity" is defined by the American Society of Addiction Medicine patient placement criteria. "Patient placement criteria" means the admission, continued service and discharge criteria set forth in the most recent version of the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

TOBACCO USE CESSATION

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Tobacco use cessation expenses not covered under the Preventive Care and Immunizations benefit are covered under this Tobacco Use Cessation benefit, as explained. Tobacco use cessation service means a service that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products. The Preventive Care and Immunizations benefit and the Prescription Medication Benefit describes coverage of tobacco use cessation medications.

TRANSPLANTS

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

Transplants and transplant-related services and supplies are covered, including Hospital and outpatient Facility Fees. Services include artificial organ transplants based on medical guidelines and manufacturer recommendations. Covered Services for a transplant recipient include the following:

- heart;

- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:

    - either autologous (self-donor);
    - allogeneic (related or unrelated donor);
    - syngeneic (identical twin donor); or
    - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact Customer Service, as the list is subject to change. Gene and/ or adoptive cellular therapies are covered under the Gene Therapy and Adoptive Cellular Therapy benefit.

Donor Organ Benefits

Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such Medically Necessary procurement costs.

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment, or management of a covered medical condition.

Some Providers may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share. To learn more about how to access virtual care services or Providers that may offer lower-cost services, visit the Claims Administrator's website or contact Customer Service.

Store and Forward Services

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

"Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. For example, store and forward services include using a secure patient portal to send a picture of Your swollen ankle to Your Provider for review at a later time. Store and forward services that are not secure and HIPAA compliant are not covered, including, but not limited to:

- telephone;
- facsimile (fax);
- short message service (SMS) texting; or
- e-mail communication.

Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform, including when You are in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider or using the equipment at Your local Provider's office to have a live video call with a cardiologist in a different city. Separate charges for Facility Fees are covered in the Professional Services benefit.

Category 1 Providers for telehealth include MDLIVE. With MDLIVE, You can access a doctor from Your home, office or on the go 24 hours a day, 7 days a week and 365 days a year. Board-certified doctors can visit with You either by phone or secure video to help treat many non-emergency medical and behavioral health conditions. Doctors can diagnose Your symptoms, prescribe medication and send prescriptions to Your pharmacy of choice. To find a provider through MDLIVE, visit mdlive.com.

Registration is required before You can access a doctor with MDLIVE. You can easily sign up or activate Your account by using one of the following methods:

- Go online and visit: MDLIVE.com/regence-wa.
- Call MDLIVE's toll free number: 1 (888) 725-3097.
- Download the MDLIVE App, available on the iTunes store and Google Play.

Prescription Medications

This section explains Your benefits and cost-sharing responsibilities for Prescription Medications. Benefits will be paid under this Prescription Medications benefit, not any other provision, if a medication or supply is covered under both.

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. To view the Drug List and find medications by tier, visit the Claims Administrator's website or contact Customer Service.

DEDUCTIBLE AND COPAYMENTS

Prescription Medications are not subject to any Deductible. You are responsible for paying the following Copayment amounts at the time of purchase, if the Pharmacy submits the claim electronically. Your Copayments will be applied toward the Out-of-Pocket Maximum.

Your cost-sharing for insulin will not exceed $35 per 30-day supply or $105 per 90-day supply. Your cost-share will be applied to Your Deductible.

Your cost-sharing for certain inhaled asthma medication and epinephrine autoinjectors (per 2-pack) will not exceed $35 per 30-day supply or $105 per 90-day supply. Your cost-share will be applied to Your Deductible.

You are not responsible for any Copayment when You fill Self-Administrable Cancer Chemotherapy Medications or prescriptions for medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List found on the Claims Administrator's website or by calling Customer Service.

Prescription Medications from a Pharmacy (for each 30-day supply)

- **Tier 1:** $5 Copayment
- **Tier 2:** $25 Copayment
- **Tier 3:** $50 Copayment
- **Compound Medication:** $50 Copayment

Prescription Medications from a Home Delivery Supplier (for each 90-day supply)

- **Tier 1:** $10 Copayment
- **Tier 2:** $50 Copayment
- **Tier 3:** $100 Copayment
- **Compound Medication:** $100 Copayment

Specialty Medications (for each 30-day supply)

- **Tier 4:** $100 Copayment

Prescription Medication Supply Limits

- **Specialty Medications.** The largest allowable quantity for a Specialty Medication is a 30-day supply. The first fill is allowed at a Pharmacy. Additional fills must be obtained from the Plan's Specialty Pharmacy. However, for some Specialty Medications the first and subsequent fills must be obtained from the Plan's Specialty Pharmacy. For more information on those medications, visit the Claims Administrator's website or contact Customer Service.
- **Home Delivery Supplier.** The largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are

limited to a 90-day supply as indicated above. Specialty Medications are not allowed through Home Delivery Suppliers.

- **Nonparticipating Pharmacy.** Except as specifically provided below, a 30-day supply is the largest allowable quantity of a Prescription Medication that You may purchase from a Nonparticipating Pharmacy and for which a single claim may be submitted.
- **Participating Pharmacy.** Except as specifically provided below, a 30-day supply is the largest allowable quantity of a Prescription Medication that You may purchase from a Participating Pharmacy and for which a single claim may be submitted.
- **Multi-Month Supply.** The maximum number of days for a covered Prescription Medication that is packaged in a multiple-month supply and is purchased from a Participating Pharmacy is a 90-day supply (even if the manufacturer packaging includes a larger supply). The Copayment is based on each 30-day supply within that multiple-month supply. Oral contraceptives can be purchased for a single Copayment per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one Copayment per monthly cycle.

Emergency Fill

You may be eligible to receive an Emergency Fill for Prescription Medications at no cost to You. A list of these medications is available on the Claims Administrator's website or by calling Customer Service. The cost share amounts noted above apply to all other medications obtained through an Emergency Fill request as requested through Your Provider or by calling Customer Service. An Emergency Fill is only applicable when:

- the dispensing pharmacy cannot reach the Claims Administrator's prior authorization department by phone as it is outside of business hours; or
- the Claims Administrator is available to respond to phone calls from a dispensing pharmacy regarding a covered benefit, but cannot reach the prescriber for a full consultation.

COVERED PRESCRIPTION MEDICATIONS FOR TREATMENT OF ILLNESS OR INJURY

- Insulin and diabetic supplies are covered as follows:
  - syringes, injection aids, lancets, test strips, glucagon emergency kits and prescriptive oral agents for controlling blood sugar levels, when obtained with a Prescription Order;
  - certain continuous glucose monitors and insulin pumps (including their supplies), that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order; continuous glucose monitors and insulin pumps (including their supplies), are also covered in the Medical Benefits Section;
  - glucometers are covered under the Durable Medical Equipment benefit, however, You may have a free OneTouch meter shipped directly to Your home or office by calling 1 (855) 306-2278 or visiting OneTouch.orderpoints.com. Use the code 701RERX01.

- Non-preventive Prescription Medications for tobacco use cessation when obtained with a Prescription Order from a Participating Pharmacy;
- Prescription Medications;
- Emergency Fill five-day supply or the minimum packaging size available at the time the Emergency Fill is dispensed;
- foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States, except as may be provided under the Experimental/Investigational definition in the Definitions section of this Booklet;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P & T) Committee;
- medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List found on the Claims Administrator's website or by calling Customer Service;
- medications to treat infertility, limited to $5,000 maximum per Claimant Lifetime;
- Compound Medications (preauthorization may be required);
- Self-Administrable Cancer Chemotherapy Medication;

- Self-Administrable Prescription Medications including, but not limited to, Self-Administrable Injectable Medications and teaching doses (by which a Claimant is educated to self-inject);
- growth hormones (if preauthorized); and
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C).

COVERED PREVENTIVE MEDICATIONS, CONTRACEPTIVES AND IMMUNIZATIONS

Certain medications, contraceptives and immunizations are covered as preventive care:

- certain preventive medications as recommended by the USPSTF that are on the Drug List, including, but not limited to, aspirin, fluoride, iron, medications for tobacco use cessation, and pre-exposure prophylaxis (PrEP) for the prevention of HIV for people at a high risk of infection, when obtained with a Prescription Order;
- post-exposure prophylaxis (PEP) medications for the prevention of HIV for people at a high risk of infection after exposure, as recommended by the CDC;
- all FDA-approved oral contraceptives (combined pill, extended/continuous use combined pill, and the mini pill), contraceptive products (such as condoms, vaginal rings, patches, diaphragms, sponges, cervical caps, and spermicide), contraceptive shots or injections, and emergency contraceptives (such as levonorgestrel and ulipristal acetate);
- immunizations for adults and children according to, and as recommended by, the CDC; and
- immunizations for the purposes of travel, occupation, or residency in a foreign country.

You are not responsible for any applicable Copayments when You fill prescriptions at a Participating Pharmacy, for specific strengths or quantities of medications that are specifically designated as preventive medications by the USPSTF or HRSA, or for contraceptives or immunizations, as specified above. NOTE: The Copayment as listed in this Prescription Medications section will apply for preventive medications, contraceptives, and immunizations from a Nonparticipating Pharmacy.

FDA-approved over-the-counter contraceptive drugs, devices, and products are available from a Participating Pharmacy without a prescription and with no cost sharing. However, You must submit a claim for reimbursement for the purchase of such items. To receive reimbursement for these items, complete a Drug Claim Form and submit to the Claims Administrator for processing. The Drug Claim Form may be found at https://regence.myprime.com/v/RBW/COMMERCIAL/en/forms.html.

You are not responsible for any cost-sharing for post-exposure prophylaxis (PEP) medications from a Participating Pharmacy, as described above.

If Your Provider believes that the covered preventive medications are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service.

For a complete list of medications, visit the Claims Administrator's website or contact Customer Service.

Drugs prescribed for a use other than that stated in its FDA approved labelling, commonly referred to as off-label, will be covered as any other drug, subject to the limitations, exclusions and provisions of this Plan.

PRESCRIPTION MEDICATION CLAIMS AND ADMINISTRATION

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. There are more than 1,200 Participating Pharmacies in the Claims Administrator's Washington State network from which to choose.

You must present Your identification card to identify Yourself when obtaining Prescription Medications from a Pharmacy or Home Delivery Supplier. If You do not present Your identification card You may be charged more than the Covered Prescription Medication Expense.

Drug List Changes

Any removal of a Prescription Medication from the Drug List will be posted on the Claims Administrator's website 30 days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as possible.

If You are taking a Prescription Medication while it is removed from the Drug List and its removal was not due to the Prescription Medication being removed from the market, becoming available over-the-counter or issuance of a black box warning by the Federal Drug Administration, the Plan will continue to cover Your Prescription Medication for the time period required to use the Drug List exception process to request continuation of coverage for the removed Prescription Medication and receive a decision through that process, unless patient safety requires an expedited replacement.

Drug List Exception Process

Non-Drug List medications are not covered by Your Prescription Medications benefit. However, a Prescription Medication not on the Drug List may be covered in certain circumstances.

"Non-Drug List" means those self-administered Prescription Medications not listed on the Drug List.

To request coverage for a Prescription Medication not on the Drug List, You or Your Provider will need to request preauthorization so that the Claims Administrator can determine that a Prescription Medication not on the Drug List is Medically Necessary. Your Prescription Medication not on the Drug List may be considered Medically Necessary if:

- medication policy criteria are met, if applicable;
- You are not able to tolerate a covered Prescription Medication(s) on the Drug List;
- Your Provider determines that the Prescription Medication(s) on the Drug List is not therapeutically effective for treating Your covered condition; or
- Your Provider determines that a dosage required for effective treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on the Claims Administrator's website. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's website.

Once preauthorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your Plan and will apply toward any Deductible or Out-of-Pocket Maximum.

Claims Submitted Electronically

Participating Pharmacies will submit claims electronically. You must pay any required Copayment at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Nonparticipating Pharmacy will be paid directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as the applicable Copayment to the Nonparticipating Pharmacy at the time of purchase.

Claims Not Submitted Electronically

It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to any applicable Copayment.

However, when a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, complete a Prescription Medication claim form and mail a copy of the form and the Prescription Medication receipt to the Claims Administrator. To find the Prescription Medication claim form, visit the Claims Administrator's website or contact Customer Service.

You will be reimbursed based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from a Participating Pharmacy.

Home Delivery

You can use home delivery services to purchase covered Prescription Medications. Home delivery coverage applies when Prescription Medications are purchased from a Home Delivery Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Home Delivery Suppliers.

You may also obtain covered Prescription Medications from a non-contracted home delivery Pharmacy, if the non-contracted home delivery Pharmacy is registered and agrees to dispense covered Prescription Medications according to the same terms and conditions as those provided by a Home Delivery Supplier. In this case, covered Prescription Medications dispensed by the non-contracted home delivery Pharmacy will be covered in the same manner as covered Prescription Medications dispensed by a Home Delivery Supplier.

To buy Prescription Medications through the mail, simply send all of the following items to a Home Delivery Supplier at the address shown on the prescription home delivery form (which also includes refill instructions) available on the Claims Administrator's website or from the Plan Sponsor:

- a completed prescription home delivery form;
- any Copayment; and
- the original Prescription Order.

PREAUTHORIZATION

Some Prescription Medications may require preauthorization before they are dispensed. The Claims Administrator notifies Category 1 and 2 Providers and Participating Pharmacies which Prescription Medications require preauthorization. Prescription Medications that require preauthorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require preauthorization will not be covered until they are preauthorized. For a list of medications that require preauthorization or if You have any questions, visit the Claims Administrator's website or contact Customer Service.

LIMITATIONS

The following limitations apply to this Prescription Medications section, except for certain over-the-counter preventive medications and contraceptives as specified in the Covered Preventive Medications, Contraceptives and Immunizations provision:

Maximum Quantity Limit

For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.

For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Claimant's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.

Any amount over the established maximum quantity, except if the Claims Administrator determines the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

Refills
Refills obtained from a Pharmacy are covered when You have taken 75 percent of the previous prescription or 70 percent of the previous topical ophthalmic prescription. However, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription. Refills obtained from a Home Delivery Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at the Claims Administrator's discretion on a case-by-case basis. You may request an exception by calling Customer Service.

If You receive maintenance medications for chronic conditions, You may qualify for prescription refill synchronization which allows refilling Prescription Medications on the same day of the month. For further information on prescription refill synchronization, call Customer Service.

Prescription Medications Dispensed by Excluded Pharmacies
The Claims Administrator does not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the Office of the Inspector General (OIG) list. A Pharmacy may be excluded if it has been investigated by the OIG and appears on the OIG's exclusion list.

You will be notified if You are receiving medications from a Pharmacy that is later determined to be an excluded Pharmacy so that You may obtain future Prescription Medications from a non-excluded Pharmacy. Up to the time of notification, Your previously submitted claims will still be processed.

Discounts or Manufacturer Coupons
Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon may not apply toward Your Out-of-Pocket Maximum.

PRESCRIPTION MEDICATION COST-SHARE ASSISTANCE
Your Plan Sponsor has coordinated with an alternate funding service to provide a cost-share assistance program for a select list of Prescription Medications. The program is separate from Your benefits under this Plan and is designed to reduce or eliminate any out-of-pocket expenses for qualifying Prescription Medications. If You are eligible to participate, the Claims Administrator will contact You and help You enroll. Upon enrollment in the program, a review will be conducted to locate cost-sharing assistance for You based on Your specific Prescription Medication. If cost-sharing assistance is identified and You are eligible but choose not to enroll, You will be responsible for any Deductible, Copayment, and/or Coinsurance as explained in this Prescription Medications Section. Whether You choose to enroll in the program or not, Your cost-sharing responsibility under this Prescription Medication Benefit will remain the same throughout the Calendar Year.

EXCLUSIONS
In addition to the exclusions in the General Exclusions section, the following exclusions apply to this Prescription Medication Benefits section:

Biological Sera, Blood or Blood Plasma

Bulk Powders
Non-FDA approved bulk powders that are not included on the Claims Administrator's Drug List (which requires a Prescription Order by a Physician or Practitioner).

Cosmetic Purposes
Prescription Medications used for Cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth, except as related to a covered medical condition; anti-aging; or repair of sun-damaged skin.

Devices or Appliances
Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits section).

Diagnostic Agents
Medications used to aid in diagnosis rather than treatment. Coverage for these medications may otherwise be provided under the Medical Benefits section.

Digital Therapeutics
Except as included on the Claims Administrator's Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications
The Plan does not cover foreign Prescription Medications for non-Emergency Medical Conditions while outside the United States.

General Anesthetics
Coverage for general anesthetics may otherwise be provided under the Medical Benefits section.

Glucometers
Coverage for glucometers is provided under the Medical Benefits section.

Insulin Pumps and Pump Administration Supplies
Coverage for insulin pumps and supplies is provided under the Medical Benefits section, except as specifically indicated in this Prescription Medications section.

Medical Foods
Coverage for these products may otherwise be provided under the Medical Benefits section.

Medications that are Not Considered Self-Administrable
Coverage for these medications may otherwise be provided under the Medical Benefits section or as specifically indicated in this Prescription Medications benefit.

Nonprescription Medications
Medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements, except medications included on the Claims Administrator’s Drug List, approved by the FDA, and prescribed by a Physician or Practitioner licensed to prescribe Prescription Medications. This includes medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Coverage for these medications may otherwise be provided under the Medical Benefits section. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)

Prescription Medications Not Approved by the United States Food and Drug Administration (USFDA)

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not on the Drug List
Except as provided through the Drug List Exception Process provision, Prescription Medications that are not on the Drug List are not covered.

Prescription Medications Not within a Provider's License
Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications with Therapeutic Alternatives
Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives, or over-the-counter (nonprescription) alternatives, unless the higher cost Prescription Medications are Medically Necessary.

Prescription Medications without Examination
The Plan does not cover prescriptions made by a Provider without recent and relevant in-person or virtual care examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS
The following definitions apply to this Prescription Medications section:

Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references (or as specified by the Claims Administrator) as a Brand-Name Medication based on manufacturer and price.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA and may be subject to review for Medical Necessity.

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Home Delivery Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Home Delivery Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.

Drug List means the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Drug List. It is available on the Claims Administrator's website or by calling Customer Service. Medications are reviewed and selected for inclusion in the Drug List by an outside committee of Providers, including Physicians and Pharmacists.

Emergency Fill means a limited dispensed amount of medication that allows time for the processing of a preauthorization request. Emergency fill only applies to those circumstances where a Claimant goes to a contracted Pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by the Claims Administrator) as a Generic Medication. "Equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. Medications available only from one source (also referred to as "single source") are not considered Generic Medications. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a Generic or Brand-Name Medication, the Claims Administrator will decide.

Home Delivery Supplier means a home delivery Pharmacy with which the Claims Administrator has contracted for home delivery services.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works and its possible adverse effects and perform other duties as described in their state's Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. A Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to submit claims electronically.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists, all of whom are free from conflict of interest of drug manufacturers and the majority of whom are free from conflict of interest of Your coverage, who review the medical and scientific literature regarding medication use and provide input and oversight of the development of the Drug List and medication policies.

Prescription Medication (also Prescribed Medication) means a medication or biological that relates directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included on the Claims Administrator's Drug List.

Prescription Order means a written prescription or oral request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Administrable Prescription Medications, Self-Administrable Medications, Self-Administrable Injectable Medications, or Self-Administrable Cancer Chemotherapy Medications means a Prescription Medication labeled by the manufacturer as intended to be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician's office or clinic). For purposes of this definition, Self-Administrable Cancer Chemotherapy Medications include oral Prescription Medications used to kill or slow the growth of cancerous cells. Information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability is used to determine a Self-Administrable Medication. Your status, such as Your ability to administer the medication, will not be considered when determining whether a medication is self-administrable.

Specialty Medication means a medication that may be used to treat complex conditions, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C. Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit the Claims Administrator's website or contact Customer Service.

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit the Claims Administrator's website or contact Customer Service.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Drug List that is approved for coverage at the Tier 3 benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Tier 4 benefit level.

Tier 1 means a category of medications that includes Generic Medications and may include some Brand-Name Medications. Tier 1 medications are categorized based on their cost and/or how well they work compared to other medications that treat the same condition.

Tier 2 means a category of medications that includes Brand-Name Medications and may include some Generic Medications. Tier 2 medications are categorized based on their cost and/or how well they work compared to other medications that treat the same condition.

Tier 3 means a category of medications that includes Brand-Name Medications and may include some Generic Medications. Tier 3 medications are categorized based on their cost and/or how well they work compared to other medications that treat the same condition.

Tier 4 means Specialty Medications.

General Exclusions

The following are the general exclusions from coverage. Other exclusions may apply and, if so, will be described elsewhere.

SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them, are not covered.

Activity Therapy

Creative arts, play, dance, aroma, music, equine, or other animal-assisted, recreational, or similar therapy; and sensory movement groups.

Adventure, Outdoor, or Wilderness Interventions and Camps

Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
    - blindness;
    - deafness/hardness of hearing;
    - a Mental Health Condition; or
    - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this Booklet.

Assisted Reproductive Technologies

Except as provided in the Infertility Treatment benefit or in the Prescription Medications section, assisted reproductive technologies (regardless of underlying condition or circumstance) or other artificial means of conception are not covered.

Certain Therapy, Counseling, and Training

Except as provided in the Compsych Employee Assistance Program, the following therapies, counseling and training services are not covered: educational, vocational, social, image, self-esteem, milieu or marathon group therapy, premarital or marital counseling, job skills or sensitivity training.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection, unless otherwise required by applicable law.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic Services and Supplies

This exclusion does not apply to services that are prescribed as Medically Necessary for Gender Affirming Treatment, to the extent such services are permitted under applicable law and are in accordance with accepted standards of care.

Counseling in the Absence of Illness

Counseling in the absence of Illness, except as required by law.

Custodial Care
Non-skilled care and helping with activities of daily living not covered under the Palliative Care benefit.

Dental Services
Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

Family Counseling
Family counseling is excluded unless the patient is a child or adolescent with a covered diagnosis, and the family counseling is part of the treatment.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes (except for certain sales taxes relating to Durable Medical Equipment); surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law or as outlined in the Durable Medical Equipment benefit.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of Emergency Medical Conditions or for coverage provided by Medicaid. Expenses from government facilities outside the Service Area are not covered under the Plan (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Growth Hormone Therapy
Growth hormone therapy, except as provided under the Prescription Medication Benefits section of the Booklet.

Hearing Devices
Except for cochlear implants or as provided in the Hearing Instruments and Services benefit, over-the-counter hearing aids or other hearing devices are not covered.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, mental health and substance use disorders or for anesthesia purposes.

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's voluntary participation in an activity where the Claimant is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, the Plan may recover the payment from the person paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies
Services, substances, and supplies that are illegal as defined under federal law.

Individual Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids, services and supports provided under an individualized education plan developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility Treatment
Except as provided in the Infertility Treatment benefit and in the Prescription Medications section or to the extent Covered Services are required to diagnose such condition, treatment of infertility and uterine transplants are not covered.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions), and any services or supplies provided under an Investigational protocol. Refer to the expanded definition of Experimental/Investigational in the Definitions section.

Liposuction for Cosmetic Purposes

Motor Vehicle Coverage and Other Insurance Liability
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to the Booklet.

Non-Direct Patient Care
Services that are not considered direct patient care or virtual care, including charges for:

- appointments scheduled and not kept ("missed appointments");
- preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the Virtual Care benefit.

Obesity or Weight Reduction/Control
Except as provided in the Bariatric Services or Nutritional Counseling benefits, as required as part of the USPSTF, HRSA, or CDC requirements, as required by law, or as otherwise provided by any AWC Trust-sponsored care management and wellness programs, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to: medical treatment; medications; surgical treatment (including treatment of complications, revisions, and reversals); or programs.

Orthognathic Surgery
Except for treatment of the following, orthognathic surgery is not covered:

- orthognathic surgery due to an Injury;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- congenital anomalies.

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Personal Items
Items that are primarily for comfort, convenience, contentment, Cosmetics, hygiene, environmental control, education, or general physical fitness. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes, weightlifting equipment, and therapy or service animals, including the cost of training and maintenance, are not covered.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Claimant's Provider.

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

Reversal of Sterilization
Services and supplies related to reversal of sterilization.

Routine Foot Care

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Medical Benefits section or for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-medical self-care, and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:
    - teach a person how to use Durable Medical Equipment or how to care for a family member; or
    - provide a supportive environment focusing on the Claimant's long-term social needs when rendered by individuals who are not Providers.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. "Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes. Such purposes include, but are not limited to, admission to or remaining in a school, camp, sports team, the military or any other institution; athletic training evaluation; legal proceedings, such as establishing paternity or custody; qualification for employment or return to work, marriage, insurance, occupational injury benefits, licensure or certification; or travel, immigration or emigration.

Sexual Dysfunction
Treatment, services and supplies for or in connection with sexual dysfunction, regardless of cause, except for covered Mental Health Services.

Subscription, Membership and Access-Related Fees
Fees for accessing care, treatment, or advice are not covered, whether the access is for virtual or in-person care. Excluded fees include, but are not limited to:

- concierge fees;
- subscription fees;
- membership fees;
- retainer fees;
- VIP or priority access fees; and
- any other access-related fees.

Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, Your Acting as a Surrogate. "Maternity and related medical services" includes otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Refer to the Maternity Care benefit and/or Subrogation and Right of Recovery provision for more information.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.

Third-Party Liability
Services and supplies for treatment of Illness, Injury or health condition for which a third-party is or may be responsible.

Travel and Transportation Expenses
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits section, travel and transportation expenses are not covered.

Vision Care
Routine eye examinations, vision hardware, visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Wigs
Wigs or other hair replacements regardless of the reason for hair loss or absence.

Work-Related Conditions
Except when a Claimant is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement.

If an Illness or Injury could be considered work-related, a Claimant will be required to file a claim for workers' compensation benefits before the Claims Administrator will consider providing any benefits under this coverage.

Claims Administration

This section explains administration of benefits and claims, including situations where Your health care expenses are the responsibility of a source other than the Plan. Payment of benefits will be made in accordance with the terms and conditions of this Booklet.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims payment is due, the Claims Administrator decides whether to pay the Claimant, Provider and Claimant jointly, or the Provider directly subject to any legal requirements.

Category 1 and Category 2 Claims and Reimbursement

You must present Your Plan identification card to a preferred or participating Provider and furnish any additional information requested. The Provider will give the Claims Administrator the information needed to process Your claim.

A preferred or participating Provider will be paid directly for Covered Services. These Providers have agreed to accept the Allowed Amount as payment for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible, Copayment and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Category 3 Claims and Reimbursement

In order for Covered Services to be paid, You or the nonparticipating Provider must first send the Claims Administrator a claim. If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the claim. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis; and
- the patient's name and the group and identification numbers.

The Claims Administrator's standard policy is to make payment for nonparticipating Provider claims directly to the Provider or, with submission of sufficient documentation that the Claimant has already "paid in full," solely to the Claimant.

Nonparticipating Providers may not agree to accept the Allowed Amount as payment for Covered Services. You may be responsible for paying any difference between the amount billed by the nonparticipating Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. For nonparticipating Providers, the Allowed Amount may be based upon the billed charges, as determined by the Claims Administrator, or as otherwise required by law.

Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Claim Determinations

Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. You will be notified of the extension within the initial 30-day period and provided an explanation of why the extension is necessary. If additional information is required to process

the claim, You will be allowed at least 45 days to provide it. If the Claims Administrator does not receive the requested information within the time allowed, the claim will be denied.

CONTINUITY OF CARE

You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the Category 1 or Category 2 benefit level, if Your Provider was a contracted preferred or participating Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud).

To qualify for continued coverage, You must be:

- undergoing a course of treatment for a certain serious and complex condition from the Provider;
- undergoing a course of institutional or inpatient care from the Provider;
- scheduled to undergo non-elective surgery from the Provider (including postoperative care following surgery);
- pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- determined to be terminally ill and receiving treatment for such Illness from the Provider.

The Claims Administrator will notify You of Your right to receive continued care from the Provider or You may contact the Claims Administrator with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Plan and provided on the same terms and conditions as any other preferred or participating Provider. Your Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copayment and/or Coinsurance. Contact the Claims Administrator's Customer Service for further information and guidance.

CLAIMS RECOVERY

If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery includes the right to deduct the mistakenly paid amount from future benefits that would have been provided the Participant or any Beneficiaries, even if the mistaken payment was not made on that person's behalf.

If the Plan makes an overpayment to a Provider, the Claims Administrator may reduce payments to the Provider, in the amount of the overpayment, for otherwise Covered Services for current and/or future Provider claims on Your or Your Beneficiaries' behalf. If a Provider to whom an overpayment was made has patients who are participants in other health plans insured or administered by the Claims Administrator, the Claims Administrator may reduce payments otherwise owed to the Provider from such other health plans by the amount of the overpayment.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). All recovered amounts will be credited to the Plan.

This claims recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration section for additional information.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. No adult covered person hereunder may assign any rights that they may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan. These provisions will apply to all claims arising from Your Illness or Injury, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Injury, Illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health Plan is always secondary to automobile no-fault coverage, personal Injury protection coverage, medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Injury, Illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an Injury, Illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Injury, Illness or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Injury, Illness or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any provider) You agree that if You receive any payment as a result of an Injury, Illness or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have, whether or not You choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, Illness or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Injury, Illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Workers' Compensation

If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Future Medical Expenses

Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which benefits would normally be provided. However, the amount of any Covered Services excluded under this provision will not exceed the amount of Your recovery.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your

present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

MAINTENANCE OF BENEFITS

The Maintenance of Benefits (MOB) provision applies when You have health care coverage under more than one plan (This Plan and an Other Plan). These plans are defined below.

The order of benefit determination rules govern the order which each plan will pay a claim for benefits. The plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that an Other Plan may cover some expenses. The plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total Allowable Expense.

Maintenance of benefits is the form of coordination used by This Plan and it is important to note that this Maintenance of Benefits provision limits what This Plan will pay when it is in other than the Primary Plan position so that This Plan's payment will not cause the total benefits available under all plans to exceed what This Plan would have paid if it had been primary. This means that it is not necessarily advantageous for Your dependents to enroll under multiple plans because the total payments from all plans may not be more than what would have been paid had This Plan been the only coverage.

Definitions

For the purpose of this section, the following definitions shall apply:

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

- Other Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- Other Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under the above bullet points is a separate plan. If a plan has two parts and coordination of benefits rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan means the part of the Booklet providing the health care benefits to which the MOB provision applies and which may be reduced because of the benefits of Other Plans. Any other part of the Booklet providing health care benefits is separate from This Plan. A contract may apply one coordination of benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a "Primary Plan" or "Secondary Plan" when You have health care coverage under more than one plan.

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering You. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering You is not an Allowable Expense.

When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the plans provides coverage for private Hospital room expenses.
- If You are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If You are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

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

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

Order of Benefit Determination Rules

When You are covered by two or more plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any Other Plan. A plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide Category 3 benefits. A plan may consider the benefits paid or provided by an Other Plan in calculating payment of its benefits only when it is secondary to that Other Plan.

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers You other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers You as a dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering You as a dependent, and primary to the plan covering You as other than a dependent (for example, a retired employee), then the order of benefits between the two plans is reversed so that the plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the Other Plan is the Primary Plan.

Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a child is covered by more than one plan the order of benefits is determined as follows:

- For a child whose parents are married or are living together, whether or not they have ever been married:
  - The plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
  - If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.

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

  - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that

plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;

- If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
- If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

  The plan covering the Custodial Parent, first;

  The plan covering the spouse of the Custodial Parent, second;

  The plan covering the noncustodial parent, third; and then

  The plan covering the spouse of the noncustodial parent, last.

- For a child covered under more than one plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee. The plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a dependent of an active employee and You are a dependent of a retired or laid-off employee. If the Other Plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

COBRA or State Continuation Coverage. If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law, the plan covering You as an employee, member, subscriber or retiree or covering You as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the Other Plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage. The plan that covered You as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the plan that covered You the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of This Plan or Other Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of this Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided will not total more than the amount that would have been paid had This Plan been the sole plan.

For example, say You are employed by the Plan Sponsor and You cover Yourself and Your spouse under This Plan, and Your spouse is also covered under their employer's plan. If Your spouse incurs an expense covered under both plans and Your spouse's plan is the Primary Plan, This Plan, when paying

as the Other Plan, would either pay the amount which when added to the Primary Plan's payment would equal the amount This Plan would have paid had it been the Primary Plan or nothing if the Primary Plan's payment exceeded the amount This Plan would have paid had it been the Primary Plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these MOB rules and to determine benefits payable under This Plan and Other Plans. The Claims Administrator may get the needed facts from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and Other Plans covering You. The Claims Administrator need not tell, or get the consent of, any person to do this. You, to claim benefits under This Plan, must give the Claims Administrator any facts they need to apply those rules and determine benefits payable.

Facility of Payment

If payments that should have been made under This Plan are made by an Other Plan, the amount determined to be appropriate to satisfy the intent of this provision may be remitted to the Other Plan. The amounts paid to the Other Plan are considered benefits paid under This Plan. To the extent of such payments, this Plan is fully discharged from liability.

Right of Recovery

This Plan has the right to recover excess payment whenever it has paid Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. This Plan may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

If You are covered by more than one health benefit plan, and You do not know which is Your Primary Plan, You or Your Provider should contact any one of the health plans to verify which plan is primary. The health plan You contact is responsible for working with the other plan to determine which is primary and will let You know within 30 calendar days.

CAUTION: All health plans have timely claim filing requirements. If You or Your Provider fail to submit Your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If You experience delays in the processing of Your claim by the primary health plan, You or Your Provider will need to submit Your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claim processing, if You are covered by more than one plan You should promptly report to Your Providers and plans any changes in Your coverage.

Out-Of-Area Services

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When You receive care outside of the Claims Administrator's Service Area, You may receive it from Providers as described below. Providers contracted with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the preferred Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the participating Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Some Providers ("nonparticipating Providers") don't contract with the Host Blue.

BlueCard Program

In the BlueCard Program, when Covered Services are received within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what was agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Providers that participate in the BlueCard Program.

When Covered Services are received outside the Claims Administrator's Service Area and the claim is processed through the BlueCard Program, the amount the Claimant pays for Covered Services is calculated based on the lower of:

- the billed charges for the Covered Services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" is a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Provider or a group of Providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of Providers. Host Blues may use several factors to set an estimated or average price, including types of settlements, incentive payments, and/or other credits or charges. Estimated and average pricing may also take into account adjustments to correct Host Blue estimates of past prices. However, such adjustments will not affect the price used for the Claimant's claim because those adjustments will not be applied after a claim has already been paid.

Value-Based Programs

You may receive Covered Services under a Value-Based Program ("VBP") inside a Host Blue's service area. Host Blue may pay Providers that participate in a VBP for reaching agreed-upon cost and quality goals, meeting outcome measures, and coordinating care between its Providers. You will not be responsible for paying fees associated with a VBP, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state law may require a surcharge, tax, or other fee. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Out-of-Network Providers Outside the Claims Administrator's Service Area

When Covered Services are provided outside of the Claims Administrator's Service Area by Out-of-Network Providers, the amount the Claimant pays will normally be based on either Host Blue's Out-of-Network Provider local payment or pricing arrangements required by applicable state law. Other payment methods may be used in certain situations, such as billed charges for Covered Services, the payment that would have been made if the health care services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment to determine the amount that will be paid for services

provided by Out-of-Network Providers. In any of these situations, the Claimant may be responsible for the difference between the Out-of-Network Provider's billed amount and the Plan's payment for Covered Services. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global® Core ("BCBS Global® Core") when accessing Covered Services. BCBS Global® Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although BCBS Global® Core helps you access a provider network, the network is not served by a Host Blue.

You may have to pay the Provider upfront and submit any claims to the Claims Administrator Yourself in order to obtain reimbursement for those services. When You pay for Covered Services outside the United States, You should complete and submit a BCBS Global® Core claim form with the Provider's itemized bill(s) to the service center (address is on the form) to initiate claims processing. If You contact the BCBS Global® Core service center for assistance, in most cases, Hospitals will not require You to pay for covered inpatient services (except for any applicable Deductible, Copayment, and/or Coinsurance). In such cases, the Hospital will also submit Your claims to the service center.

If You need medical assistance services or help locating a Provider outside the United States, or if You need assistance with a claim submission, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary. The claim form is available from the Claims Administrator, the service center, or online at **www.bcbsglobalcore.com**.

Covered Services received from Providers outside the United States may not be subject to state or federal protections from surprise or balance billing, and therefore You may be billed for balances beyond any Deductible, Copayment, and/or Coinsurance for Covered Services.

Appeal Process

This provision describes the process for submitting an appeal. You may submit an appeal, as detailed below, if You or Your Representative want a review of a claim denial or other action under the Plan. There are two levels of appeal, as well as additional voluntary appeal levels You may pursue. Situations that require a faster decision may qualify for an expedited appeal.

NOTE: For all appeals, written materials provided in support of the appeal that include others' medical or health records and other personal health information should not be submitted.

WHAT YOU MAY APPEAL

You may appeal an Adverse Benefit Determination. Appeals can be initiated through either written or verbal request using any of the following methods:

Method of Request	Contact Information
Fax	1 (877) 663-7526
Phone	Call the Claims Administrator at 1 (800) 752-9985
Mail	Attn: ASO Appeals and Grievances Regence BlueShield P.O. Box 1106 Lewiston, ID 83501-1106

Each level of appeal, except voluntary external review, must be pursued within 180 days of Your receipt of either the Claims Administrator's determination or the original adverse decision that You are appealing. If You don't appeal within this time period, You will not be able to pursue an appeal. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony. If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular appeal process, You or Your Provider may request an expedited appeal.

APPEAL DETERMINATION TIMING

Type of Appeal	When to Expect a Response
Internal appeal involving a Post-Service investigational issue	In writing, within 30 days of the Claims Administrator's receipt of the appeal.
Internal appeal involving all other issues, including a Pre-service preauthorization	In writing, within 15 days of the Claims Administrator's receipt of the appeal.
Expedited appeal	Verbal notice as soon as possible, but no later than 72 hours of receipt of the appeal, followed by written notice mailed to You within 3 calendar days of the verbal notice.
Voluntary external appeal by an Independent Review Organization (IRO)	In writing, within 45 days after the IRO receives the request.
Voluntary expedited appeal by an Independent Review Organization (IRO)	Verbal notice as soon as possible, but no later than 72 hours of the IRO's receipt of the appeal, followed by written notice within 48 hours of the verbal notice.

INTERNAL APPEALS

There are two levels of internal appeal reviewed by an employee(s) of the Claims Administrator who was not involved in the initial decision that You are appealing.

First-Level Internal Appeals

First-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals.

Second-Level Internal Appeals

Second-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial or the first-level decision.

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO)

A voluntary appeal to an IRO is available only after You have exhausted all of the applicable non-voluntary levels of appeal, or if the Claims Administrator has failed to adhere to all claims and internal appeal requirements. Voluntary external appeals are available for:

- issues involving medical judgment, including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or
- the determination that a treatment is Investigational.

Voluntary external appeals must be requested within four months of Your receipt of the notice of the prior adverse decision. The Claims Administrator coordinates voluntary external appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external appeal by an IRO is optional, and You should know that other forums may be used as the final level of appeal to resolve a dispute You have under the Plan.

EXPEDITED APPEALS

An expedited appeal is available if one of the following applies:

- the application of regular appeal time frames on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

First-Level Expedited Appeal

The first-level expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. First-level expedited appeals are reviewed by the Claims Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination.

Voluntary External Expedited Appeal – IRO

If You disagree with the decision made in the first-level expedited appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service or concurrent), You may request a voluntary external expedited appeal to an IRO. The criteria for a voluntary external expedited appeal to an IRO are the same as described above for a voluntary external appeal.

The Claims Administrator coordinates voluntary external expedited appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. Choosing the voluntary external expedited appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external expedited appeal by an IRO is optional and You should know that other forums may be used as the final level of expedited appeal to resolve a dispute You have under the Plan.

INFORMATION

If You have any questions about the appeal process, contact Customer Service at 1 (800) 752-9985 or write to Customer Service at the following address: Regence BlueShield, P.O. Box 1106, Lewiston, ID 83501-1106 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including when based on a determination of a Participant's or Beneficiary's eligibility to participate in a Plan, and including, with respect to group health plans, 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 Medically Necessary or appropriate. An Adverse Benefit Determination subject to review also includes a denial or rescission of coverage, and any request that the Claims Administrator reconsider a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits (i.e., contractual exclusions or limitations), including the admission to, or continued stay in, a health care facility.

Independent Review Organization (IRO) is an independent Physician review organization that acts as the decision-maker for voluntary external appeals and voluntary external expedited appeals and that is not controlled by the Claims Administrator.

Post-Service means a request to change an Adverse Benefit Determination for care or services that have been received, or any claim for benefits that is not considered Pre-Service.

Pre-Service means any claim for benefits which the Claims Administrator must approve in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the appeal. The Representative may be an attorney, Your authorized Representative, or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the appeal. No authorization is required from the parent(s) or legal guardian of an enrolled dependent child who is less than 13 years old. For expedited appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each appeal level). If no authorization exists and is not received in the course of the appeal, the determination and any personal information will only be disclosed to You, Your Representative, or Your treating Provider.

Eligibility and Enrollment

This section contains the terms of eligibility under the Plan described in this Booklet for an employee and their dependents. It explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual open enrollment period. It also describes when coverage under the Plan begins for You and/or Your eligible dependents, though payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

INITIAL ELIGIBILITY, WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Plan Sponsor and Your employer. Your coverage begins on the on the first day of the month after Your enrollment has been accepted by the Plan. For dependents who are eligible and are included in Your enrollment application, coverage begins on the same date as the employee's coverage.

Except as described under the special enrollment provision, if You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual open enrollment period to enroll.

Employees

To qualify for eligibility under the Plan, active employees must be employed by a Member Employer of the AWC Trust and must be hired into a position for which the Member Employer provides Plan benefits. Your employer may impose a probationary or waiting period before You become eligible. Contact Your employer for more information about the eligibility requirements for employees.

Dependents

Your dependents listed below are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your registered domestic partner and if specifically included as eligible by Your employer, Your non-registered domestic partner. Contact the AWC Trust for questions about whether Your non-registered domestic partner is eligible for the Plan.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:

    - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or mental or physical disability that began before the child's 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity acceptable to the Plan, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:

    - the child is a Beneficiary immediately before their 26th birthday; or
    - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as a dependent on either a parent's or legal guardian's group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form for children age 26 or older is available by visiting the Claims Administrator's website or by calling Customer Service. The Claims Administrator

may request updates on the child's disability at reasonable times as considered necessary (but this will not be more often than annually following the dependent's 28th birthday).

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual open enrollment period.

New Dependents

If You acquire a new dependent after Your Effective Date and Your new dependent is eligible for the Plan, You may enroll the dependent by completing and submitting an enrollment request to the Claims Administrator. Application for enrollment of a new child by birth, adoption or Placement for Adoption must be made within 60 days of the date of birth, adoption or Placement for Adoption. Application for enrollment of a new spouse or domestic partner (and children of the new spouse or domestic partner, if any) must be made within 30 days of Your marriage or domestic partnership. Coverage for such dependents will begin on their Effective Dates. For a new child by birth, the Effective Date is the date of birth. For a new child adopted or placed for adoption within 60 days of birth, the Effective Date is the date of birth. The Effective Date for any other child by adoption or Placement for Adoption is the date of Placement for Adoption. For other newly eligible dependents (new spouse, domestic partner and children of a new spouse or domestic partner), the Effective Date is the first day of the month following receipt of the application for enrollment.

NOTE: The regular benefits of the Plan will be provided for a newborn child of a Claimant for up to 21 days following birth. Such benefits will not be subject to enrollment requirements for a newborn as specified here, or the payment of a separate charge for coverage of the child. Coverage, however, is subject to all provisions, limitations and exclusions of the Plan. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn.

Loss of Other Coverage

You, Your Spouse (or Your Domestic Partner) and/or any eligible children are eligible to enroll for coverage under the Plan within 30 days from the date of loss of coverage under another plan (except for loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll) if You qualify under one of the following rules:

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
    - an employer's contributions to that other plan are terminated;
    - exhaustion of federal COBRA or any state continuation; or
    - loss of eligibility for the other plan, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Note that loss of coverage or eligibility does not include a loss because of a failure to timely pay all or a portion of the cost of coverage or when termination of the other coverage was because of fraud. It also doesn't include Your decision to voluntarily terminate the other coverage, though it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the first day of the month after the Claims Administrator receives Your application for enrollment.

Qualification for Premium Assistance

You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll for coverage under the Plan within 60 days from the date of the following qualifying event:

- You and/or Your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

Coverage will be effective on the first of the calendar month following the date the Claims Administrator receives Your enrollment application.

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

When Coverage Ends

This section describes the situations when Plan coverage will end for You and/or Your Beneficiaries. You must notify the Claims Administrator within 30 days of the date on which an enrolled Beneficiary is no longer eligible for coverage.

No person will have a right to receive any benefits after the Plan terminates. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all obligations to provide You or Your Beneficiary Plan benefits for Covered Services received after the date of termination. This applies whether or not You or Your Beneficiary is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Plan was in effect.

MEMBER EMPLOYER TERMINATION

If Your employer ceases to be a Member Employer of the AWC Trust or Your employer ceases to offer coverage under this Plan, coverage ends for You and Your Beneficiaries on the date Your employer ceases to be a Member Employer or ceases to offer coverage under this Plan.

WHAT HAPPENS WHEN PARTICIPANTS ARE NO LONGER ELIGIBLE

If a Participant is no longer eligible as explained in the following paragraphs, coverage ends for You and Your Beneficiaries on the last day of the month in which the Participant's eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the continuation of coverage provisions.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Beneficiaries on the last day of the month following the date on which eligibility ends.

NONPAYMENT

If You fail to make required timely contributions to the cost of coverage under the Plan, Your coverage will end for You and all Beneficiaries.

FAMILY AND MEDICAL LEAVE

If Your employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") or under applicable state family and medical leave law, You will remain eligible for the Plan during Your leave.

During the leave, You must continue to make payments for coverage through Your employer on time. The provisions described here will not be available if the Plan terminates or Your employer ceases to be a Member Employer.

If You and/or Your Beneficiaries elect not to remain enrolled during the leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan on the date You return from the leave. In order to reenroll after You return from a leave, You must sign and submit a new enrollment form.

Entitlement to leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person who does not return to active employment following leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the leave.

The provisions and administration described here are based on the requirements of applicable law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and applicable law, the minimum requirements of the law will govern.

PAID LEAVE OF ABSENCE

If You are granted a non-family and medical temporary paid leave of absence by Your employer, You can continue coverage during Your paid leave. Payments for the coverage must be made through Your employer in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of Your employer.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Beneficiaries on the last day of the month in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions.

Divorce or Annulment

Eligibility ends for Your ex-spouse and Your ex-spouse's children (who are not also Your children) on the last day of the month following the date a divorce or annulment is final. You are required to provide notice of divorce or annulment within 30 days of its occurrence.

Death of the Participant

If You die, coverage for Your Beneficiaries ends on the last day of the month in which Your death occurs.

Termination of Domestic Partnership

If Your domestic partnership terminates (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the ex-domestic partner and the ex-domestic partner's children who are not also Your children on the last day of the month following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. This termination provision does not apply to any termination of domestic partnership that occurs as a matter of law because the domestic partners marry (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage under Washington law).

Loss of Dependent Status

- Eligibility ends on the last day of the month in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the date in which an enrolled child is removed from placement due to disruption of placement before legal adoption.

OTHER CAUSES OF TERMINATION

Claimants may be terminated for any of the following reasons.

Fraudulent Use of Benefits

If You or Your Beneficiary, or someone acting on Your or Your Beneficiary's behalf, engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan will terminate for You and/or that Claimant.

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional misrepresentation of material fact or fraud regarding a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Member Employer), any action allowed by law or contract may be taken by the Plan, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

COBRA Continuation of Coverage

You and Your covered Beneficiaries may continue coverage under this Plan in certain circumstance when coverage would otherwise be lost.

COBRA coverage is the same as the coverage provided to employees and their Beneficiaries.

COBRA continuation is available to Your Beneficiaries if they lose coverage under the Plan because of one of the following "qualifying events":

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce, the marriage is annulled, or Your registered domestic partnership is terminated;
- You and Your non-registered domestic partner terminate the domestic partnership; or
- Your child loses eligibility for coverage, due to age or loss of disability status.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. When the qualifying event is the end of Your employment, the reduction of hours of Your employment, or Your death, Your Member Employer will notify the AWC Trust of the qualifying event within 30 days of the event.

You must give notice of some qualifying events. You or a family member is responsible for notifying the AWC Trust of a qualifying event which is Your divorce, annulment, termination of domestic partnership or Your child ceasing to be eligible for coverage. Such notice must be provided in writing within 60 days of the qualifying event to the AWC Trust as provided in the "Notice Procedures" below.

Failure to furnish notice in accordance with these rules will result in a loss of coverage continuation rights that are otherwise available under COBRA.

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. If coverage ends due to Your termination of employment (other than for gross misconduct), or a reduction in hours, coverage may be continued for up to 18 months. If coverage ends due to any other qualifying event, coverage may be continued for up to 36 months beginning with the date coverage ended.

If an individual was originally only eligible for 18 months of COBRA, in the event of a disability (as defined under the applicable provisions of the Social Security Act) existing at the time of Your termination or reduction in hours or existing within the first sixty days of COBRA continuation coverage, You and other Beneficiaries on COBRA continuation are eligible for an additional 11 months of continuation coverage (for a total of 29 months). The disability must also last at least until the end of the initial 18-month period of COBRA continuation coverage. The person(s) wishing to receive the additional 11 months of coverage must notify the AWC Trust in writing at the address below under "Notice Procedures" of the determination of disability by the Social Security Administration within 60 days of the later of (a) the date of the disability determination by the Social Security Administration; or (b) the date on which the qualifying event occurred that entitled You and/or Your Beneficiaries to receive COBRA continuation coverage with a maximum duration of 18 months.

However, such written notice must be furnished to the AWC Trust before the end of the first 18 months of COBRA continuation coverage. A copy of the Social Security determination must be included with the notice. If during the additional 11-month period it is determined that the person is no longer disabled under the Social Security Act, the right to continuation coverage ceases. The affected person must notify the AWC Trust in writing at the address below under "Notice Procedures" that the person is no longer disabled within 30 days of such determination. Failure to furnish a written notice in accordance with the Plan rules and the Notice Procedures will result in a loss of coverage continuation rights that are otherwise available under COBRA.

For spouses, domestic partners, or children who were originally only eligible for 18 months of COBRA continuation, if during the first eighteen (18) months one of the three following events happens which would also have caused loss of Plan, these Beneficiaries are eligible for an additional 18 months of continuation coverage (for a total of 36 months): (1) death of the Employee; (2) divorce, annulment, or termination of domestic partnership of the Employee; or (3) the Dependent child ceasing to be eligible for the Plan. You or a Beneficiary is responsible for notifying the AWC Trust in writing at the address below under "Notice Procedures" of such an event within 60 days of its occurrence. Reasonable documentation of the second qualifying event must be included with the notice. For example, if the second qualifying event is Your death, a certified copy of the death certificate must be included. If it is Your divorce, a copy of the final divorce decree must be included. Failure to furnish written notice in accordance with these rules will result in a loss of coverage continuation rights that are otherwise available under COBRA.

COBRA may also be elected, for the remainder of the parents' own continuation coverage, for any dependent child born to, placed for adoption with or adopted by an employee or former employee during the period of COBRA continuation coverage. When a Beneficiary becomes eligible for continuation coverage when or after an employee becomes entitled to Medicare, the Beneficiary is entitled to continuation for a period of no less than 36 months from the date the employee became entitled to Medicare.

COBRA coverage will terminate if Your employer terminates group coverage on all its employees or if the COBRA recipient becomes covered under Medicare or covered under a new group health plan after the COBRA election (as long as the recipient is not subject to a pre-existing condition limitation in the other group plan). (Note that plans will not be able to impose pre-existing condition limitations beginning in 2014). You or a family member must notify the AWC Trust in writing at the address listed below under "Notice Procedures" if a person on COBRA becomes entitled to Medicare or becomes covered under another group health plan within 30 days of such entitlement or coverage. However, COBRA coverage will not be terminated based on the fact that the individual had other group coverage (including Medicare) in place prior to electing COBRA. Non-payment of premiums will also terminate coverage at the end of a 31-day grace period.

Following the termination of continuation coverage, no further benefits will be payable unless eligible charges were actually incurred prior to the date continuation coverage terminates.

Special considerations in deciding whether to elect COBRA

In considering whether to elect COBRA, You and Your Beneficiaries should take into account special enrollment rights that may be available under federal law. An individual has the right to request special enrollment in another group health plan for which the individual is otherwise eligible (such as a plan sponsored by Your spouse's employer) with 30 days after group health coverage under this Plan ends because of one of the qualifying events listed above. Individuals will also have the same special enrollment right at the end of the COBRA coverage if COBRA coverage lasts for the maximum time it is available to the individual.

In addition to COBRA coverage, You and Your Beneficiaries should consider health coverage alternatives that may be available through the Health Insurance Marketplaces. In the Marketplace, individuals may be eligible, depending upon household income and other factors, for a new kind of tax credit that lowers monthly premiums right away. At the Marketplace, premiums, deductibles, and out-of-pocket costs can be seen before a decision is made to enroll in any available insurance. Being eligible for COBRA generally does not limit eligibility for a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace in Washington, visit **healthplanfinder.org**. For information about health insurance options in other states, visit **healthcare.gov**.

How to apply and pay for COBRA

A qualified beneficiary must follow the steps below to apply and pay for COBRA continuation coverage.

Within 14 days after the AWC Trust receives notice of a qualifying event, a COBRA Enrollment Form will be mailed to the address listed on Your employment record.

Complete the form and return it to the address on the form within 60 days of the later of (a) the date of the notification of the right to choose COBRA coverage; or (b) the date coverage would otherwise end. **IF A COMPLETED FORM IS NOT SUBMITTED BY THIS DUE DATE, THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE WILL BE LOST.**

Send a check or money order for the required premium for the appropriate month(s) to the address listed below. The envelope must be postmarked within 45 days from the date COBRA is elected.

Payments are due each month on the due date listed on the billing statement, but must be postmarked no later than 31 days after the due date. COBRA participants will receive premium-due billing statements each month, which will provide the address to which payments must be mailed.

Each person eligible for COBRA has an independent right to elect COBRA continuation coverage. A spouse or domestic partner may elect, but not decline, COBRA continuation coverage on behalf of the other spouse or domestic partner. Either parent may elect or decline COBRA continuation coverage on behalf of their children, except that children who have reached the age of majority or who are otherwise considered adults under state law must decline COBRA continuation coverage on behalf of themselves.

Cost of COBRA

Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation coverage, plus an administration fee, even if the Member Employer contributes toward the cost of those not on COBRA continuation. The administration fee is two percent.

COBRA Continuation Coverage and Retiree Coverage from the AWC Trust

If You retire and You have exhausted the COBRA self-payment provision, You will no longer be eligible for coverage under the Plan. However, if You retire from active employment with a Member Employer, You may be eligible to enroll on another group retiree plan. If You meet the eligibility criteria for a retiree plan, You may, but need not, exhaust Your COBRA continuation coverage before You enroll in the retiree plan.

Contact the AWC Trust at 1 (800) 562-8981 for more information about eligibility for retiree coverage.

Address Changes

In order to protect Your and Your Beneficiaries' rights, You should keep Your employer and the AWC Trust informed in writing of any changes in the address or marital status or domestic partnership of family members. You should also keep a copy of any notices sent to the AWC Trust, Your employer, or anyone else concerning COBRA.

This notice may not describe all information concerning Your continuation rights under federal law. More complete information regarding such rights is available by contacting the AWC Trust at 1 (800) 562-8981 or benefitinfo@awcnet.org.

COBRA Notice Procedures

Any notice that You provide must be in writing to the AWC Trust as described below: Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered addressed as follows:

Mail to:
AWC Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275

Fax to:
AWC Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
(425) 771-1226

Hand-deliver to:
AWC Employee Benefit Trust
1076 Franklin Street SE
Olympia, WA 98501

OR

AWC Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275

If mailed, the notice must be postmarked no later than the last day of the required notice period. In addition to the information required by the Plan for the notice, all notices must state:
• The name of the Plan,
• The name and address of the employee or former employee,
• The name(s) and address (es) of the qualified beneficiary (ies), and
• The qualifying event and the date it happened.

If the qualifying event is a divorce, annulment, or termination of domestic partnership, the notice must include a copy of the divorce decree, decree of annulment or similar document.

General Provisions and Legal Notices

This section explains various general provisions and legal notices regarding Your benefits under this coverage.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about certificates relating to period(s) of creditable coverage under the Plan should be directed to the Plan Sponsor, or to the Claims Administrator at P.O. Box 1106, Lewiston, ID 83501-1106.

CHOICE OF FORUM

Any legal action arising out of the Plan must be filed in a court in the state of Washington.

GOVERNING LAW AND DISCRETIONARY LANGUAGE

The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Washington without regard to its conflict of law rules. The Plan Administrator, the Plan Sponsor, delegates the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the Plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the Plan. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan, and the court will determine the level of discretion that it will accord determinations.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. The Plan, the AWC Trust and the Claims Administrator do not provide any health care services, and cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are not employees or agents of the Plan, the AWC Trust or the Claims Administrator. The Claims Administrator, the AWC Trust or the Plan are not responsible for the quality of health care You receive.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to provide the benefits of the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

NO WAIVER

The failure or refusal of either party to demand strict performance of the Plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Plan Sponsor's authorized officers.

NONASSIGNMENT

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

NOTICES

Any notice to Claimants required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant will be addressed to the Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address (COA)

form for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Administrator or Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be mailed to the Claims Administrator's Customer Service address. However, any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices: The AWC Trust has a Notice of Privacy Practices that is applicable to the Plan. It is available by calling 1 (800) 562-8981 or by visiting http://www.awcnet.org/Portals/0/Documents/Trust/HIPAAPrivacyPolicyAWCTrust.pdf.

The Claims Administrator also has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Claims Administrator's website listed below.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence BlueShield, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Regence BlueShield to use the Blue Shield Service Mark in the state of Washington for those counties designated in the Service Area, and that Regence BlueShield is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence BlueShield and that no person or entity other than Regence BlueShield will be held accountable or liable to the Plan Sponsor or the Claimants for any of Regence BlueShield's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator and by the AWC Trust for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law. This information will be used in accordance with the Claims Administrator's Notice of Privacy Practices and the AWC Trust's Notice of Privacy Practices. To request a copy of the Claims Administrator's Notice visit the Claims Administrator's website or contact Customer Service. The AWC Trust's Notice of Privacy Practices is available by calling 1 (800) 562-8981 or by visiting **http://www.awcnet.org/Portals/0/Documents/Trust/HIPAAPrivacyPolicyAWCTrust.pdf**.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, Hospital, long-term care or other medical facility; or
- a Physician, dentist, Pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

- billing statements;
- claim records;

- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to Plan operations.

You have the right to request, inspect and amend any records that the Claims Administrator has that contain Your personal health information. Contact Customer Service to make this request.

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

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

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. For information on preauthorization, contact Your Plan Administrator.

TAX TREATMENT

The Claims Administrator does not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions described in the Booklet; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act mandates coverage for certain breast reconstruction services in connection with a covered mastectomy.

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, coverage under the Plan will be provided (subject to the same provisions as any other benefit) for:

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

Definitions

The following are definitions of important terms used in this Booklet. Other terms are defined where they are first used.

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes only the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Oregon in the state of Oregon, and Regence BlueCross BlueShield of Utah in the state of Utah.

Allowed Amount means:

- For preferred and participating Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For nonparticipating (non-contracted) Providers, the amount the Claims Administrator has determined to be reasonable charges or has negotiated for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact Customer Service.

Ambulatory Surgical Center means a distinct facility or that portion of a facility that operates exclusively to provide surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. Ambulatory Surgical Center does not mean: (1) individual or group practice offices of private Physicians or dentists that do not contain a distinct area used for specialty or multispecialty outpatient surgical treatment on a regular and organized basis; or (2) a portion of a licensed Hospital designated for outpatient surgical treatment.

Beneficiary means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Agreement between the Plan Sponsor and the Claims Administrator.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Claimant's Effective Date.

Category 1 means the benefit reimbursement level for services that are received from a contracted Provider with the Claims Administrator in Your Provider network who provides services and supplies to Claimants in accordance with the provisions of this coverage. Your Provider network is Preferred and may include the Claims Administrator's Affiliates. Category 1 also means a Provider outside the area that the Claims Administrator or one of the Claims Administrator's Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program as a preferred Provider. Refer to the Out-of-Area Services section for additional details. Category 1 reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 1 Providers include only the Claims Administrator's identified Centers of Excellence for the particular therapy.

Category 2 means the benefit reimbursement level for services that are received from a contracted Provider with the Claims Administrator in Your Provider network who provides services and supplies to Claimants in accordance with the provisions of this coverage. Your Provider network is Participating and may include the Claims Administrator's Affiliates. Category 2 also means a Provider outside the area that the Claims Administrator or one of the Claims Administrator's Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program as a participating Provider. Refer to the Out-of-Area Services section for additional details. Category 2 reimbursement is

generally a lower payment level than Category 1, but You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 2 Providers include any Provider that is not one of the Claims Administrator's identified Centers of Excellence for the particular therapy.

Category 3 means the benefit reimbursement level for services that are received from a Provider that is a non-contracted (nonparticipating) Provider. Category 3 reimbursement is generally the lowest payment level of all categories, and You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 3 Providers include any Provider that is not one of the Claims Administrator's identified Centers of Excellence for the particular therapy.

Claimant means a Participant or a Beneficiary.

Claims Administrator means Regence, which provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide new medical supplies, equipment and devices in accordance with the provisions of this coverage.

Cosmetic means services or supplies (including medications) that are provided primarily to improve or change appearance to normal structures of the body.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in this Booklet.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home.

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.

Emergency Medical Condition means a medical, mental health, or substance use disorder condition that manifests itself by acute symptoms of sufficient severity (including, but not limited to, severe pain or emotional distress) such that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Claimant's health, or with respect to a pregnant Claimant, the Claimant's health or the health of the unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Experimental/Investigational means a Health Intervention that the Claims Administrator has classified as Experimental or Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in Peer-Reviewed Medical Literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Experimental or Investigational. A Health Intervention not meeting all of the following criteria, is, in the Claims Administrator's judgment, Experimental or Investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-Reviewed Medical Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:

    - Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
    - Standard Reference Compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Upon receipt of a fully documented claim or request for preauthorization related to a possible Experimental or Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Please contact the Claims Administrator by calling Customer Service at 1 (800) 752-9985 or by visiting the Claims Administrator's website at **regence.com** for details on the information needed to satisfy the fully documented claim or request requirement. You may also have the right to an expedited Appeal. Refer to the Appeal Process section for additional information on the Appeal process.

Facility Fee means any separate charge or billing by a Provider-based clinic in addition to a professional fee for office visits that is intended to cover room and board, building, electronic medical records systems, billing, and other administrative or operational expenses.

Family means a Participant and any Beneficiaries.

Gender Affirming Treatment means Medically Necessary Covered Services (to the extent such services are permitted under applicable law) provided by a Provider and prescribed in accordance with generally accepted standards of care to treat gender dysphoria.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A

Hospital has an attending medical staff consisting of one or more Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Host Blue means the local Blue Cross and/or Blue Shield Licensee outside of the Claims Administrator's Service Area.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder (which is otherwise defined in this Booklet).

Injury means physical damage to the body caused by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Lifetime means the entire length of time a Claimant is continuously covered under the Plan (which may include more than one coverage) through the Plan Sponsor with the Claims Administrator.

Maintenance Therapy means a Health Intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed. This is particularly applicable to patients with chronic, stable conditions where skilled supervision/intervention is no longer required and further clinical improvement cannot reasonably be expected from continuous ongoing care. This includes but is not limited to:

- a general exercise program to promote overall fitness;
- ongoing treatment solely to improve endurance and fitness;
- passive exercise to maintain range of motion that can be carried out by non-skilled persons;
- programs to provide diversion or general motivation;
- therapy that is intended to maintain a gradual process of healing or to prevent deterioration or relapse of a chronic condition; or
- therapy that is supportive rather than corrective in nature.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, 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 or supply 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 and other health care Providers practicing in relevant clinical areas and any other relevant factors. Medical Necessity determinations are made by health professionals applying their training and experience, and using applicable medical policies developed through periodic review of generally accepted standards of medical practice.

Member Employer means a business entity qualifying for membership or participation in the AWC Trust and choosing to provide coverage under the Plan to its employees and their dependents as Participants and Beneficiaries, respectively.

Participant means an employee of a Member Employer who is eligible under the terms described in this Booklet, has completed an enrollment form and is enrolled under this coverage.

Physician means an individual who is duly licensed as a doctor of medicine, doctor of osteopath (D.O.), doctor of podiatric medicine (D.P.M.) or doctor of naturopathic medicine (N.D.) who is a Provider covered under this Plan.

Placement for Adoption means an assumption of a legal obligation for total or partial support of a child in anticipation of adoption of the child. Upon termination of all legal obligation for support, placement ends.

Practitioner means a healthcare professional, other than a Physician, who is duly licensed to provide medical or surgical services. Practitioners include, but are not limited to:

- chiropractors;
- psychologists;
- registered nurse practitioners;
- advanced registered nurse practitioners (ARNPs);
- certified registered nurse anesthetists;
- dentists (doctor of medical dentistry, doctor of dental surgery, or a denturist; and
- other professionals practicing within the scope of their respective licenses, such as massage therapists, physical therapists and mental health counselors.

Provider means a Hospital, Skilled Nursing Facility, ambulatory services facility, Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Regence refers to Regence BlueShield.

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include an office or independent clinic outside a retail operation, or an Ambulatory Surgical Center, urgent care center, Hospital, Pharmacy, rehabilitation facility or Skilled Nursing Facility.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Service Area means the geographic area in Washington state where the Claims Administrator has been authorized by the State of Washington to sell and market this Plan. The Service Area for this Plan is the following counties:

Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom and Yakima.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Appendix: Value-Added Services and Programs

This Plan includes access to the value-added services and AWC Trust-sponsored care management and wellness programs detailed in this Appendix. Services and programs may be provided through third-party program partners who are solely responsible for their services. These value-added services and programs are voluntary, not insurance and are offered in addition to the benefits in this Booklet. These value-added services may work alongside Your coverage. Such services are otherwise covered in the benefits provisions of this Booklet.

For additional information regarding any of these value-added services or programs, visit the Claims Administrator's website or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

CARE MANAGEMENT

Receive one-on-one help and support in the event You have a chronic, serious or sudden Illness or Injury. An experienced care management nurse will serve as Your single point of contact and personal advocate to help You understand Your Providers' instructions, help prepare You for an elective surgical procedure, assist in coordinating overall care, connecting to special medical expertise and accessing other Plan Sponsor services and programs. Your nurse is supported by a multidisciplinary team made up of doctors, social workers, Pharmacists and behavioral health experts that can be accessed for additional consultation. The goal is to offer assistance in navigating through Your health care needs, including working with Your community resources to provide a personalized touch and to enhance the quality of Your wellbeing. Care management nurses proactively outreach by telephone and educational mailings or You may request support by directly contacting a nurse. To learn more, call 1 (866) 543-5765.

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM (EAP)

The ComPsych global service center is staffed by dedicated clinical, legal, financial, wellness, behavioral and work life experts. Coverage includes access to the robust website resources, counseling resources, financial resources, and legal resources.

Extensive online resources can be accessed at: **guidanceresources.com** (web id is: **trusteap71**). Call ComPsych for assistance anytime-24 hours a day, seven days a week at 1 (800) 570-9315.

ComPsych does not provide BlueCross BlueShield services and is a separate company solely responsible for its products and services.

HEALTH CENTRAL

Health Central powered by Castlight is Your personalized, secure health and benefits resource. Employees, spouses, and domestic partners with AWC Trust medical coverage can access benefit contact information, wellness programs and tools, and wellness rewards at awctrust.org or by downloading the Castlight app.

HEALTH COACHING

Drive positive change in Your life and achieve Your goals. One-on-one video coaching can help You stay on track. Vida Health matches you to a free health coach to help You reach a healthy weight, lower your blood sugar, feel less stress, and build healthy habits. Health coaching provided by Vida Health can be accessed by visiting Health Central at awctrust.org or by downloading the Vida Health app through the Castlight platform. Health coaching is available for employees, spouses and domestic partners.

To learn more go to: vida.com/AWCTrust.

Castlight does not provide BlueCross BlueShield services and is a separate company solely responsible for its products and services.

HINGE HEALTH

The Hinge Health joint, spine, and muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. In addition, based upon Your specific health condition, You may have access to a customized care plan including guided exercise therapy, one-on-one video coaching with a care team, curated health education, and behavior change support. You may be eligible for the following at no cost to You:

- exercise bands;
- wearable motion sensors and chargers;
- wearable pain relief device; and/or
- yoga mat.

To learn more, visit hinge.health/awctrust or call (855) 902-2777.

Hinge Health is a separate company that provides virtual physical therapy services.

INFUSION SITE OF CARE

If You receive certain infused or injectable drugs, You may be notified about an opportunity to receive Your care at an alternative location. Alternative locations such as standalone infusion sites, doctor's offices and home infusion can offer more comfort, convenience, and reduced costs compared to most Hospital settings. You may contact the Claims Administrator for a list of drugs included in the Infusion Site of Care program or for help finding an alternative location.

MDLIVE TELEHEALTH

With MDLIVE, You can access a doctor from Your home, office or on the go 24 hours a day, 7 days a week and 365 days a year. Board-certified doctors can visit with You either by phone or secure video to help treat many non-emergency medical and behavioral health conditions. Doctors can diagnose Your symptoms, prescribe medication and send prescriptions to Your pharmacy of choice.

Registration is required before You can access a doctor with MDLIVE. You can easily sign up or activate Your account by using one of the following methods:

Go online and visit: MDLIVE.com/regence-wa.
Call MDLIVE's toll free number: 1 (888) 725-3097.
Download the MDLIVE App, available on the iTunes store and Google Play.

MDLIVE is a separate company that provides telehealth services.

MENTAL HEALTH DIGITAL

At times, we all struggle with our moods. Anxious or depressive thoughts can weigh us down. Seeking help when you need it and focusing on your mental health is important. Now you can use Web and mobile tools to help you feel better and stay mentally strong. Mental Health Digital by Teledoc Health is a confidential online resource, personalized to help improve your mood. These self-help resources are designed to help empower you to become – and stay – mentally and physically healthy. This valuable resource offers in-the-moment mood tracking, and it offers you immediate stress-relief activities that can help you achieve lasting, healthy change.

Mental Health Digital offers:

- a variety of mood-improving resources;
- step-by-step eLearning modules;
- interactive tools;
- weekly action plans;
- daily inspiration; and
- is private and confidential.

To Sign Up:

- go to **TeladocHealth.com/start/mental-health-digital**;

- when prompted for an Access Code, enter: **AWCTRUST**;
- complete the sign-up process and personal profile.

Teledoc Health is a separate company that provides care and disease management services.

PREGNANCY PROGRAM

Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. The Pregnancy Program can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1 (888) JOY-BABY (569-2229) or visit the Claims Administrator's website right away to get started.

NURSE ADVICE

You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care (whether to seek care in an emergency room, urgent care, office visit or self-care at home). This service is available to You on an unlimited basis at no additional cost. However, if You are experiencing a medical emergency, immediately call 911 instead.

REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning up to $25 in gift cards for completion of well-being activities such as an online health risk assessment;
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

WELLNESS NEWSLETTER

The Wellness Newsletter offers wellness articles, benefit information, tips, and recipes delivered quarterly to Your home.

WONDR HEALTH

Wondr is a weight management program that is clinically proven to help You lose weight, sleep better, stress less, and so much more. The Wondr program will teach You simple skills that are based on behavioral science, so You can enjoy Your favorite foods and feel better than ever – at no cost to You. The program is available to employees, spouses, and domestic partners. Interested individuals can apply and get started any time through their Health Central account.

To learn more go to: www.wondrhealth.com/AWCTrust.

Wondr does not provide BlueCross BlueShield services and is a separate company solely responsible for its products and services.

For more information, contact the AWC Trust at 1 (800) 562-8981, e-mail at benefitinfo@awcnet.org, or visit our website at awctrust.org.

You may also contact Regence at 1 (800) 752-9985, write to us at P.O. Box 1106, Lewiston, ID 83501-1106, or visit the website at regence.com.

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For more information

Contact the AWC Trust at **1-800-562-8981**, email at benefitinfo@awcnet.org, or visit our website at awctrust.org.

You may also contact Regence at **1-800-752-9985**, write to us at P.O. Box 2998, Tacoma, WA 98401-2998, or visit the website at **regence.com**.

Regence

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