2019 BOOKLET FOR:

TRICO COMPANIES LLC

Group Number: 10030826

Regence Classic[SM] Medical Plan

Regence

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 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, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

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

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'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 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 ballooji-ma 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

Regence BlueShield

Street Address:
1800 Ninth Avenue
Seattle, WA 98101

Claims Address:
P.O. Box 30271
Salt Lake City, UT 84130-0271

Customer Service/Correspondence Address:
MS CS B32B
P.O. Box 1827
Medford, OR 97501-9884

Appeals Address:
P.O. Box 1408
Lewiston, ID 83501

This Booklet provides the evidence and a description of the terms and benefits of coverage. The agreement between the Group and Regence BlueShield (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

This Booklet is effective December 1, 2019, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void.

Keep in mind that references to "You" and "Your" refer to both the Enrolled Employee and Enrolled Dependents (except that in the eligibility and continuation of coverage sections, the terms "You" and "Your" mean the Enrolled Employee only). The terms "We," "Us" and "Our" refer to Regence BlueShield and the term "Group" means the organization whose employees may participate under this coverage. Other terms are defined in the Definitions section or where they are first used and are designated by the first letter being capitalized.

Using Your Regence Classic[SM] Booklet

YOUR PARTNER IN HEALTH CARE

We are pleased that Your Group has chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. This plan provides coverage that's comprehensive, affordable, and provided by a partner You can trust in times when it matters most.

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

This plan allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** Your Provider Network is: Preferred. When You see a Provider from this network, You save the most and Your out-of-pocket expenses will be lower when choosing an In-Network Provider and You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** When You see an Out-of-Network Provider, Your out-of-pocket expenses will generally be higher than seeing an In-Network Provider. An Out-of-Network Provider may bill You for any balances beyond the Deductible, Copayment and/or Coinsurance (sometimes referred to as balance billing).

For each benefit, We indicate 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 MEMBERSHIP

When Your Group purchased Regence Classic, You were provided with more than just great coverage. You acquired membership with Us, which offers additional valuable services. The advantages of membership include access to 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. You also have access to Our Web site, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Member card handy to log on. Use the secure Member Web site to:

  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - discover discounts on select items and services*;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

*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 Us. Any such discounts or coupons are complements to the group health plan, but are not insurance.

Enhanced Services, Support, and Access

Your Group has chosen to include enhanced services, support, and access. These enhancements will allow You to take increased advantage of Your health plan and better control over Your and Your Family's health. Such services may include, but are not limited to:

- Enhanced convenience and options for access to medical care. These may include additional resources for You to receive covered medical care, such as enhanced virtual care options that are integrated with Your telehealth and telemedicine, durable medical equipment, preventive, behavioral health, and/or other benefits. You may also be offered increased ease in accessing non-Covered

Services, such as cosmetic services or in integrating care for complex and multi-Provider conditions.
- Healthcare and vitality assistance tools. You may have tools that enable You to make and track medical appointments; manage health care expenses; receive support in caring for others; remember to timely refill prescriptions and perform regular self-care; track weight, food, and exercise statistics; receive coaching; and more.
- Non-medical lifestyle enhancements. These may include access or assistance with non-medical services, such as resilience, mindfulness, yoga, or stress reduction programs and pet wellness and insurances services.

Your Group's enhancements can be accessed through a single-sign on by visiting Our Web site, or by contacting Customer Service. These services are specialized and may change over time. Your use of these additional services selected by Your Group is voluntary. In some cases, We may have an affiliation with the entity that performs the services purchased by Your Group. The use of these services may result in savings or value to You, Your employer, and Us. ANY SUCH ENHANCED SERVICES, SUPPORT, AND ACCESS ARE COMPLEMENTS TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.

CONTACT INFORMATION

- **Call Customer Service:** 1 (888) 367-2112 (TTY: 711) if You have questions, would like to learn more about Your plan, or would like to request written or electronic information regarding any health care plan We offer. Phone lines are open Monday-Friday 5 a.m. - 8 p.m. and Saturday 8 a.m. - 4:30 p.m. Pacific Time.
- **Visit Our Web site: regence.com.**
- **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.
- **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.
- **Health Plan Disclosure Information.** You may receive written or electronic copies of the following health plan disclosure information by calling the Customer Service telephone number or access that information through Our Web site at **https://www.regence.com/web/regence_individual/member-notices**. Available disclosure information includes, but is not limited to:

    - A listing of covered benefits, including prescription drug benefits;
    - A copy of the current Drug List;
    - Exclusions, reductions, and limitations to covered benefits;
    - Our policies for protecting the confidentiality of Your health information;
    - Cost of premiums and Member cost-sharing requirements;
    - A summary of Adverse Benefit Determinations and the Grievance Processes; and
    - Lists of In-Network primary care and specialty care Providers.

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 Medical Benefits section to see exactly how they are applied.

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, dollar amount, or specified time period) has been reached.

Allowed Amounts for Covered Services provided are also applied toward the Deductible and against any specific Maximum Benefit.

You will be responsible for the total billed charges for benefits in excess of the Maximum Benefits, if any, and for charges for any other service or supply not covered under this plan, regardless of the Provider rendering such service or supply.

OUT-OF-POCKET MAXIMUM

You can meet the Out-of-Pocket Maximum by Your payments of Deductibles, Copayments, and Coinsurance for all categories as indicated in the Medical Benefits and Prescription Medication Benefits sections.

Amounts You pay for non-Covered Services or in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your Copayment and/or Coinsurance for Prescription Medications resulting from the use of a drug manufacturer coupon does not count toward the Out-of-Pocket Maximum. 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.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year.

The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when two or more family members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount. One Member may not contribute more than the individual Out-of-Pocket Maximum amount.

COPAYMENTS

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

Refer to the Medical Benefits and Prescription Medication Benefits sections to understand what Copayments You are responsible for.

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)

Once You have satisfied any applicable Deductible and Copayment, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our 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 We pay varies, depending on the service or supply You received and who rendered it.

We do not reimburse Providers for charges above the Allowed Amount. However, an In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount. See the Definitions section for descriptions of Providers.

Coinsurance amounts applicable to Prescription Medications are located in the Prescription Medication Benefits section.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after You satisfy the

Calendar Year Deductible. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year.

The Family Calendar Year Deductible is satisfied when three or more covered family members meet the Family Deductible amount. One Member may not contribute more than the individual Deductible amount. We do not pay for services applied toward the Deductible. Refer to the Medical Benefits section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW

Many provisions in this Booklet (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.

If Your Contract renews on a day other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the plan's renewal date will carry over into the next contract period. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement less any amount already satisfied under the previous contract during the same Calendar Year.

Some benefits may have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Calendar Year. Those exceptions are noted in the Medical Benefits and Prescription Medications Benefits sections.

Medical Benefits

This section explains how Your coverage pays for Covered Services. Referrals are not required under this plan, and nothing contained in this Booklet is designed to restrict Your choice of Provider for care or treatment of an Illness or Injury. Most benefits are listed alphabetically. All covered benefits are listed under each benefit table.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury, including chronic disease management services (except for any covered preventive care). All covered benefits are subject to the limitations, exclusions and provisions of this plan. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions section for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. 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 In-Network Provider level, with reimbursement based on the lesser of either the amount paid to an In-Network 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 Our Web site or contact Customer Service.

If You choose to access new medical supplies, equipment, and devices through Our Web site, We 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.

Some services may require preauthorization. Contracted Providers may be required to seek preauthorization from Us before providing some services for You. You will not be penalized if the Contracted Provider does not obtain preauthorization from Us in advance and the service is later determined to be not covered. Non-Contracted Providers are not required to obtain preauthorization from Us prior to providing services. You may be liable for the cost of services provided by a Non-Contracted Provider if those services are not Covered Services nor Medically Necessary. You may request that a Non-Contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Per Member: $7,150
Per Family: $14,300

COPAYMENTS AND COINSURANCE

Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES

Per Member: $3,000
Per Family: $9,000

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). 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 Our Web site or contact Customer Service.

If You choose to access new medical supplies, equipment, and devices through Our Web site, We 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: Covered Services that do not meet these criteria (for example, immunizations for the purposes of travel, occupation, or residency in a foreign country) will be covered the same as any other Illness or Injury.

In addition to Covered Services for Preventive Care and Immunizations by an In-Network Provider, Covered Services for Preventive Care and Immunizations provided by a Contracted Provider will be covered as an In-Network benefit as explained below.

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

- routine physical examinations, well-baby care, women's care, and health screenings including screening for obesity in adults and for adult patients 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;
- depression screening for all adults, including screening for maternal depression;
- immunizations for adults and children as recommended by the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- one 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; and
- Food and Drug Administration (FDA) approved contraceptive drugs, devices, and other products such as implants (including the insertion and removal of those devices and implants) and sterilization methods including, but not limited to, condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization.

Immunizations - Adult

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

Immunizations - Childhood

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 0% of the Allowed Amount and You pay any balance of billed charges.

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

OFFICE VISITS - ILLNESS OR INJURY

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Office visits for treatment of Illness or Injury are covered. The Copayment applies to visits in the office, home or Hospital outpatient department only. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit are not considered an office visit.

PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies are explained in the following paragraphs:

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 those to treat a congenital anomaly and foot care associated with diabetes.

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 In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network 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 Our Web site or contact Customer Service.

Professional Inpatient
Professional inpatient visits for Illness or Injury are covered. If You are admitted as an inpatient to an In-Network hospital and the admitting Practitioner also is In-Network, then benefits for associated Covered Services provided during the admission by an Out-of-Network hospital-based Practitioner (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) are eligible for coverage at the In-Network level. In addition to usual cost-sharing, You may remain responsible for any amount by which billed charges exceed the Allowed Amount. If You are admitted as an inpatient directly from the emergency room and services were not covered at the In-Network level, as described above, contact Customer Service for an adjustment to Your claims.

Radiology and Laboratory
Services for treatment of Illness or Injury, including CAT scans, PET scans, MRIs, prostate screenings, colorectal laboratory tests and mammography services are covered. This benefit does not include services covered under the Preventive Care and Immunizations benefit.

Claims for independent clinical laboratory services will be submitted to this plan or any other Blue Cross and/or Blue Shield Licensee in the locale in which the referring Provider is located, regardless of where the examination of the specimen occurred. Refer to the plan network where the referring Provider is located for coverage of independent clinical laboratory services.

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 and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medication Benefits section. For a list of covered Self-Administrable Injectable Medications, visit Our Web site or contact Customer Service.

ACUPUNCTURE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Limit: 12 visits per Member per Calendar Year	

Acupuncture visits that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. For acupuncture to treat Substance Use Disorder Conditions, refer to the Substance Use Disorder Services benefit in this Medical Benefits section.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, You pay 30% of the Allowed Amount.

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

AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

APPROVED CLINICAL TRIALS

If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the 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. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered, subject to the Deductible, Coinsurance and/or Copayments and Maximum Benefits as specified in the Medical Benefits and Prescription Medications Benefits.

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 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 Food and Drug Administration 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 Member 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 Member; or
- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

BLOOD BANK

Provider: All
Payment: After Deductible, You pay 30% of the Allowed Amount.

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

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health because treatment in a dental office would be neither safe nor effective.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Medically Necessary detoxification services.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies for diabetic self-management training and education provided by Providers with expertise in diabetes. Diabetic nutritional therapy is covered under the Nutritional Counseling benefit.

DIALYSIS - INPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Inpatient services and supplies for dialysis.

DIALYSIS - OUTPATIENT
Initial Outpatient Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

When Your Physician prescribes outpatient dialysis, regardless of Your diagnosis, hemodialysis, peritoneal dialysis, hemofiltration and home services and supplies are covered during an initial treatment period of 120 days, measured from the first day You receive dialysis treatment. This initial treatment period benefit is available once for each course of continuous or related dialysis care, even if that course of treatment spans two Calendar Years.

Supplemental Outpatient Treatment Period (Following Initial Outpatient Treatment Period)

Provider: In-Network	Provider: Out-of-Network
Payment: You pay no cost-sharing, even if You have not met Your Out-of-Pocket Maximum, and You are not responsible for any balance. We pay 125% of the Medicare allowed amount at time of service.	**Payment:** We pay 125% of the Medicare allowed amount at time of service. If You are enrolled in Medicare Part B, You pay nothing at Providers that have agreed to accept assignments of Medicare benefits. If You are not enrolled in Medicare Part B, You pay balance of billed charges, which will not apply toward the Out-of-Pocket Maximum.

Outpatient hemodialysis, peritoneal dialysis, hemofiltration and home services and supplies are covered, beginning the first day following completion of the initial treatment period, when Your Physician prescribes outpatient dialysis, regardless of Your diagnosis, for a period longer than the initial treatment period. Your kidney diagnosis may make You Medicare-eligible and, if You are enrolled in additional Medicare Part B on any basis and receive dialysis from a Medicare-participating Provider, You will not be responsible for additional out-of-pocket expenses.

In addition, a Member receiving supplemental dialysis is eligible to have Medicare Part A and Part B premiums reimbursed as an eligible expense for the duration of the Member's dialysis treatment, as long as the Member continues to be enrolled under Medicare Part A and Part B and continues to be eligible for coverage under the Contract. Proof of payment of the Medicare Part A and 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.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Durable Medical Equipment must be rendered by a Provider practicing within the scope of his or her

license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Applicable sales tax for Durable Medical Equipment and mobility enhancing equipment is also covered. 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 Member's home. Examples include oxygen equipment, wheelchairs, and insulin pumps and their supplies. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

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 In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. Claims for the purchase of Durable Medical Equipment will be submitted to this plan in the locale in which the equipment was received. To find ways to access new Durable Medical Equipment, including how to access an approved commercial seller, visit Our Web site or contact Customer Service. If You choose to access new Durable Medical Equipment through Our Web site, We 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.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After $100 Copayment per visit and Deductible, You pay 30% 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 $100 Copayment per visit and Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges. 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 exams 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:

- 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 Member from a facility; and
- in the case of a covered female Member, who is pregnant, to perform the delivery (including the placenta).

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

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. In addition to usual cost-sharing, You may remain responsible for any amount by which billed charges exceed the Allowed Amount. If services were not covered at the In-Network level, as described above, contact Customer Service for an adjustment to Your claims.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% 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 Us as a Center of Excellence for that therapy, gene therapies and/or adoptive cellular therapies and associated Medically Necessary Covered Services are covered under this benefit. You may contact Us for a current

list of covered gene and cellular therapies or to identify a Center of Excellence.

Travel Expenses

Travel expenses are reimbursed for covered gene therapy and/or adoptive cellular therapy provided at a Center of Excellence (limited to transportation, food, and lodging) for You and a companion (or two companions if You are under age 19) to a combined maximum of $7,500 per course of treatment. Reimbursable transportation includes only commercial airfare, commercial train fare, or documented auto mileage (calculated per IRS allowances) to the treatment area and local ground transportation to and from treatment within that area during the course of treatment. Documentation of travel expenses should be retained for submission for reimbursement.

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Limit: 130 visits per Member 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 that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Limit: 14 inpatient or outpatient respite care days per Member 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 his or her Family during the final stages of Illness.

Respite care to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member is also covered. Respite care days that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

HOSPITAL CARE - INPATIENT AND OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level.

In addition to usual cost-sharing, You may remain responsible for any amount by which billed charges exceed the Allowed Amount. If You are admitted as an inpatient directly from the emergency room and services were not covered at the In-Network level, contact Customer Service for an adjustment to Your claims.

Hospital confinement may not always be the best environment for treating an Illness. When You need significant long-term medical supervision, case managers or Your Providers may recommend alternative care and treatment or facilities that are:

- Not normally covered by Us;
- Covered by Us, but covered on a different basis from the original course of treatment; or
- Covered on the same basis as the original course of treatment.

In these situations, We may approve coverage for alternative care and treatment that would otherwise not be covered or when Medically Necessary treatment can be delivered more cost-effectively. Substitution of such care can be made only with Your consent and the recommendation of Your Provider, and must be based on Your medical needs.

Case management provides intervention in cases of serious Illness or Injury. Our case managers are experienced, licensed health care professionals who work with Your Physicians and other health care professionals to ensure You receive cost-effective and appropriate care.

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), Medically Necessary supplies of home birth, complications of pregnancy, termination of pregnancy and related conditions are covered for all female Members. There is no limit for the mother's length of inpatient stay. The attending Provider, if any, will determine an appropriate discharge time, in consultation with the mother.

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 Us the lesser of the amount described in the preceding sentence and the amount We have 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 Contract).

You must notify Us within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with Us as needed to ensure Our ability to recover the costs of Covered Services received by You for which We are entitled to reimbursement. To notify Us, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. More information is in the Right of Reimbursement and Subrogation 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 Member 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

In addition to Covered Services for Mental Health by an In-Network Provider, Covered Services for Mental Health provided by a Contracted Provider will be covered as an In-Network benefit as explained below.

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Mental Health Services for treatment of Mental Health Conditions are covered, including Applied Behavioral Analysis (ABA) therapy services covered for treatment of Autism Spectrum Disorders when Members seek services from licensed Providers qualified to prescribe and perform ABA therapy services. Services must meet Our clinical criteria guidelines and Providers must submit individualized treatment plans and progress evaluations.

Definitions

The following definitions apply to this Mental Health Services section:

Mental Health Conditions means mental disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders 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 Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

NEURODEVELOPMENTAL THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Inpatient limit: unlimited **Outpatient limit:** 25 visits per Member per Calendar Year for all outpatient neurodevelopmental therapy services	

Inpatient and outpatient neurodevelopmental therapy services are covered. Such services must be to restore or improve function. Covered Services are limited to physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Member's condition would result without the service.

Neurodevelopmental therapy services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies are covered under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled, if applicable, as explained in the Who Is Eligible, How to Enroll and When Coverage Begins 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 well-baby Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Limit: three visits per Lifetime (diabetic education and counseling is not subject to this limit)	

Nutritional counseling and therapy for all conditions including diabetic counseling and obesity is covered. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Braces, splints, orthopedic appliances and orthotic supplies or apparatuses purchased to support, align or correct deformities or to improve the function of moving parts of the body are covered. Orthopedic shoes, regardless of diagnosis, and off-the-shelf shoe inserts are not covered.

Orthotic devices must be provided by a Provider practicing within the scope of his or her license and must

be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item.

Reimbursement may also be available for new orthotic devices when obtained 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 In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network 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 Our Web site or contact Customer Service. If You choose to access new orthotic devices through Our Web site, We 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Limit: 30 visits per Member per Calendar Year	

Palliative care is covered when a Provider has assessed that a Member is in need of palliative care services for serious Illness (including remission support), life-limiting Injury or end-of-life. "Palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living. Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. All other Covered Services for a Member receiving palliative care remain covered the same as any other Illness or Injury.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% 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 Members 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 will be covered.

RECONSTRUCTIVE SERVICES AND SUPPLIES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Inpatient and outpatient services are covered for treatment of reconstructive services and supplies:

- to treat a congenital anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body,

caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

REHABILITATION SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Inpatient limit: 30 days per Member per Calendar Year **Outpatient limit:** 25 visits per Member per Calendar Year	

Inpatient and outpatient rehabilitation services and accommodations to restore or improve lost function because of an Injury, Illness or disabling condition are covered. Rehabilitation services include physical, occupational, and speech therapy necessary to help get the body back to normal health or function. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

RETAIL CLINIC OFFICE VISITS

Provider: In-Network	Provider: Out-of-Network
Payment: After $20 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Office visits in a Retail Clinic for treatment of Illness or Injury are covered. All other professional services performed in the Retail Clinic, not billed as an office visit, are not considered an office visit under this benefit. A surgical procedure performed in the Retail Clinic is covered according to the Professional Services benefit.

SKILLED NURSING FACILITY (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Limit: 60 inpatient days per Member per Calendar Year	

Inpatient services and supplies of a Skilled Nursing Facility are covered for 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 that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
Limit: ten spinal manipulations per Member per Calendar Year	

Chiropractic and osteopathic spinal manipulations performed by any Provider are covered. Spinal manipulations that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits in this Medical Benefits section.

SUBSTANCE USE DISORDER SERVICES

In addition to Covered Services for Substance Use Disorder by an In-Network Provider, Covered Services for Substance Use Disorder provided by a Contracted Provider will be covered as an In-Network benefit as explained below.

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $30 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Coverage for treatment of Substance Use Disorder Conditions, including 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 received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

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 Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined by Us to be 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.

TELEHEALTH

Provider: In-Network	Provider: Out-of-Network
Payment: After $10 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** You pay 100% of the billed charges. Your payment will not be applied toward the Deductible or Out-of-Pocket Maximum.

Telehealth (live audio-only communication, audio and video communication, and asynchronous (not live) store and forward services), including at home, as permitted by law, between the patient and an In-Network Provider is covered. Telehealth office visits are not covered when provided by a Provider who is not contracted with Us to provide telehealth. Such office visits will be considered Out-of-Network. Store and forward consultations between In-Network Providers are also covered. Contact Customer Service for further information and guidance.

Audio-only communication is secure telephonic communication. We only cover audio-only communication if there is a previously established patient-provider relationship. An audio-only communication must take the place of an in-person visit that would be billable by the Provider.

Store and forward technology is secure one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward services are the provider's diagnosis and medical management of the patient that result from the use of store and forward technology. You must have engaged in a live (in-person or synchronous audio and video communication) visit with Your Provider before engaging in subsequent, related store and forward services with that Provider. Coverage of store and forward services is limited to the services We have specifically contracted for that Provider to provide. Store and forward technology does not include telephone, fax or email communication.

TELEMEDICINE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Interactive (live) audio and video technology is covered for two-way communication between a patient at an originating site and a Provider at a distant site to deliver covered health care services in the form of diagnosis, consultation, or treatment in real time (i.e., during the communication). An originating site includes: Hospital; rural health clinic; federally qualified health center; Physician's or other health care Provider's office; community mental health center; Skilled Nursing Facility; or renal dialysis center, except an independent renal dialysis center.

Asynchronous (not live) store and forward technology is covered. Store and forward technology is one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Inpatient and outpatient services are covered for treatment of temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion of the TMJ;
- arthritic problems with the TMJ;
- internal derangement of the TMJ; and/or
- pain in the musculature associated with the TMJ.

"Covered Medical Services" for the purpose of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not Experimental or primarily for Cosmetic purposes.

Dental Services are not Covered Services by this plan. "Dental Services" for the purpose of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good dental practice; and
- not Experimental or primarily for Cosmetic purposes.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 30% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Transplants, including Hospital or outpatient Facility Fees, transplant-related services and supplies are covered. A transplant recipient who is covered under this plan and fulfills Medically Necessary criteria will be eligible for the following transplants:

• heart	• lung
• kidney	• pancreas
• liver	• cornea
• multivisceral	• small bowel
• islet cell	• hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions).

Transplants and related services for gene therapies or adoptive cellular therapies are covered benefits under the Gene Therapy and Adoptive Cellular Therapy benefit.

Donor Organ Benefits

Donor organ procurement costs, including Hospital or outpatient Facility Fees, are covered if the recipient is covered for the transplant under this plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such Medically Necessary procurement costs.

Prescription Medication Benefits

In this section, You will learn how Your Prescription Medication coverage works, including information about Deductibles (if any), Copayments, Coinsurance, Covered Services and payment, as well as definitions of terms specific to this Prescription Medication Benefits section.

All terms and conditions of the Contract apply to this Prescription Medication Benefits section, except as otherwise noted. Benefits will be paid under this Prescription Medication Benefits section, not any other provision, if a medication or supply is covered under both.

PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLES

Not applicable

COPAYMENTS AND COINSURANCE

After You meet any applicable Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts (at the time of purchase, if the Pharmacy submits the claim electronically). (See below for information on claims that are not submitted electronically and for information on maximum quantities.)

For Prescription Medications from a Pharmacy

• $10 for each Generic Medication
• $35 for each Preferred Brand-Name Medication on the Drug List
• $75 for each Brand-Name Medication not on the Drug List
• 50% for each Compound Medication

For Prescription Medications from a Mail-Order Supplier

• $30 for each Generic Medication
• $105 for each Preferred Brand-Name Medication on the Drug List
• $225 for each Brand-Name Medication not on the Drug List
• 50% for each Compound Medication

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 Our Website or by calling Customer Service. The cost share amounts noted in the Copayments and Coinsurance section of the Prescription Medication Benefits section 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 Our prior authorization department by phone as it is outside of business hours; or
- We are available to respond to phone calls from a dispensing pharmacy regarding a covered benefit, but cannot reach the prescriber for a full consultation.

Drug List Changes

Any removal of a Prescription Medication from Our Drug List will be posted on Our Web site 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 practicable.

For information visit Our Web site or contact Customer Service.

Brand-Name Prescription Medication Instead of Generic

If an equivalent Generic Medication is available and You choose to fill a Prescription Order with a Brand-Name Medication, even if the prescribing Provider specifies that the Brand-Name Medication must be dispensed, You will be responsible for paying the difference in cost (which does not count toward any applicable Deductible or Out-of-Pocket Maximum). The difference is calculated at the time of purchase

based upon the difference in price between the equivalent Generic Medication and the applicable Brand-Name Medication, in addition to the Copayment and/or Coinsurance (as applicable). NOTE: See the Covered Prescription Medications provision below for an exception that applies to covered preventive medications, including women's contraceptives.

COVERED PRESCRIPTION MEDICATIONS FOR TREATMENT OF ILLNESS OR INJURY

Benefits under this Prescription Medication Benefits section are available for the following:

- insulin and diabetic supplies (including but not limited to, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, urine test strips, prescriptive oral agents for controlling blood sugar levels and glucagon emergency kits, but not insulin pumps or continuous glucose monitors and their supplies), when obtained with a Prescription Order (insulin pumps and continuous glucose monitors and their supplies are covered under the Durable Medical Equipment benefit);
- 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;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee;
- 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 Member is educated to self-inject);
- growth hormones (if preauthorized); and
- Specialty Medications.

COVERED PREVENTIVE MEDICATIONS

Certain Prescription Medications are covered as preventive care:

- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- all FDA-approved prescription and over-the-counter contraception methods. These include condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, and emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
- immunizations for adults and children according to, and as recommended by, the CDC; and
- immunizations for purposes of travel, occupation, or residency in a foreign country.

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance 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 immunizations, as specified above. NOTE: The applicable Deductible, Copayment and/or Coinsurance as listed in this Prescription Medication Benefits section will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

Also, if Your Provider believes that Our covered preventive medications, including women's contraceptives, 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 Our Web site 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 Drug List.

NOTE: 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.

Self-Administrable Cancer Chemotherapy Medication

Self-Administrable Cancer Chemotherapy Medications are covered. You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill prescriptions for Self-Administrable Cancer Chemotherapy Medications.

GENERAL PRESCRIPTION MEDICATION BENEFITS INFORMATION (NETWORK, SUBMISSION OF CLAIMS AND MAIL-ORDER)

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 Our Washington State network from which to choose.

Your Member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Member with Us, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on Our Web site or by contacting Customer Service.

Claims Submitted Electronically

You must present Your Member card at a Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Coinsurance at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, We will pay the Nonparticipating Pharmacy 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 any Deductible, Copayment and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Claims Not Submitted Electronically

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 the form and receipt to Us. The Prescription Medication claim form is available on Our Web site or by contacting Customer Service. We will reimburse You based on the Covered Prescription Medication Expense, less any applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. We will send payment directly to You.

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 Deductible, Copayment and/or Coinsurance.

Mail-Order

You can also use mail-order services to purchase covered Prescription Medications. Mail-order coverage applies only when Prescription Medications are purchased from a Mail-Order Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Mail-Order Suppliers.

To buy Prescription Medications through the mail, send all of the following items to a Mail-Order Supplier at the address shown on the prescription mail-order form available on Our Web site or from Your Group (which also includes refill instructions):

- a completed prescription mail-order form;
- any Deductible, Copayment and/or Coinsurance; and
- the original Prescription Order.

Your Prescription Drug Rights

You have the right to safe and effective Pharmacy services. You also have the right to know what drugs are covered by Your plan and the limits that apply. If You have a question or concern about Your prescription drug benefits, contact Us at 1 (888) 367-2112 or visit Our Web site.

If You would like to know more about Your rights, or if You have concerns about Your plan, You may contact the Washington State Office of Insurance Commissioner at 1 (800) 562-6900 or www.insurance.wa.gov. If You have a concern about the Pharmacists or Pharmacies serving You, contact the Washington State Department of Health at 1 (360) 236-4700.

PREAUTHORIZATION

Preauthorization may be required so that We can determine that a Prescription Medication is Medically Necessary before it is dispensed. We publish a list of those medications that currently require preauthorization. This list can be found on Our Web site or by contacting Customer Service. In addition, We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

Coverage for preauthorized Prescribed Medications begins on the date We preauthorize them. If Your Prescription Medication requires preauthorization and You purchase it before We preauthorize it or without obtaining the preauthorization, the Prescription Medication may not be covered, even if purchased from a Participating Pharmacy.

LIMITATIONS

The following limitations apply to this Prescription Medication Benefits section, except for certain preventive medications as specified in the Covered Prescription Medications section:

Maximum 30-Day or Greater Supply Limit

- **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy is a 30-day supply. The first fill is allowed at a Pharmacy. Additional fills must be purchased from a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, visit Our Web site or contact Customer Service. Specialty medications are not allowed through mail-order.
- **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
- **Nonparticipating Pharmacy and 30-Day Supply.** 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. The largest allowable quantity of a covered Maintenance Medication purchased from a Nonparticipating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
- **Participating Pharmacy and 90-Day Supply.** The largest allowable quantity of a Prescription Medication that You may purchase from a Participating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.

  The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Participating Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply).

Maximum Quantity Limit

For certain Prescription Medications, We establish 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. We use 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 Member 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. We do not cover any amount over the established maximum quantity, except if We determine 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

- We will cover refills from a Pharmacy, other than for FDA-approved contraceptive drugs, 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.
- We will cover up to a 12-month supply for refills of FDA-approved contraceptive drugs from a Pharmacy or Mail Order Supplier.
- Other than FDA-approved contraceptive drugs, refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward any applicable Deductible or Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at Our discretion on a case-by-case basis. Request an exception by calling Customer Service.
- If You receive maintenance medications for chronic conditions, You may qualify for Our 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

A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription Medications from a non-excluded Pharmacy. We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the OIG list.

Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of a drug manufacturer coupon does not count toward the Out-of-Pocket Maximum.

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 Our 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; anti-aging; repair of sun-damaged skin; or reduction of redness associated with rosacea.

Diagnostic Agents

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

Foreign Prescription Medications

We do not cover foreign Prescription Medications for non-Emergency Medical Conditions while traveling outside the United States.

General Anesthetics

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

Medical Foods

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

Non-Self-Administrable Medications
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 Our 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 for the Treatment of Infertility

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 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 Lower Cost 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
We do not cover prescriptions made by a Provider without recent and relevant in-person, telehealth or telemedicine 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 Medication Benefits section:

Brand-Name Medication and Preferred 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 Us) 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 Mail-Order Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Mail-Order Supplier may not charge You more than the Covered Prescription

Medication Expense for a Prescription Medication.

Drug List means Our list of selected Prescription Medications. We established Our Drug List and We review and update it routinely. It is available on Our Web site or by calling Customer Service. Medications are reviewed and selected for inclusion in Our 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 Member 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 as specified by Us) 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, We will decide.

Mail-Order Supplier means a mail-order Pharmacy with which We have contracted for mail-order 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 his or her 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 We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. A Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have 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 Medications (also Prescribed Medications) means medications and biologicals that relate 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 Our 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. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Medication means a medication that may be used to treat complex conditions, including, but not limited to, multiple sclerosis, rheumatoid arthritis, cancer 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 Our Web site or contact Customer Service.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit Our Web site or contact Customer Service.

General Exclusions

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

PREEXISTING CONDITIONS

This coverage does not have an exclusion period for treatment of Preexisting Conditions. A Preexisting Condition normally means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specified period of time before the enrollment date.

SPECIFIC EXCLUSIONS

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits section or in the Prescription Medication Benefits section.

Activity Therapy

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

Assisted Reproductive Technologies

Assisted reproductive technologies (including, but not limited to, cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm, or embryo; in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Certain Therapy, Counseling, and Training

Educational, vocational, social, image, milieu, or marathon group therapy, premarital or marital counseling, IAP/EAP services; 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 Member's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Member'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

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Counseling

Counseling in the absence of Illness, except as covered under the Preventive Care and Immunizations benefit.

Custodial Care

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

Dental Services

Dental Services and supplies 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.

Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

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.

Family Planning
Over-the-counter contraceptive supplies, except as covered under the Prescription Medications benefit.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; 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 Us and except as required by law, such as for cases of Emergency Medical Conditions or for coverage provided by Medicaid. We do not cover government facilities outside the Service Area (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Hearing Aids, and Other Hearing Devices
Hearing aids (externally worn or surgically implanted) and other hearing devices, except for cochlear implants, or as provided in the Hearing Aids benefit, if any, in this Booklet.

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 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
Treatment of infertility, including but not limited to surgery, fertility drugs and medications is excluded.

Investigational Services
Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition of Experimental/Investigational in the Definitions section.

Motor Vehicle No-Fault Coverage
Expenses for services and supplies that have been covered or have been accepted for coverage under any automobile medical personal injury protection ("PIP") no-fault coverage. If Your expenses for services and supplies have been covered or have been accepted for coverage by an automobile medical personal injury protection ("PIP") carrier, We will provide benefits according to the Contract once Your claims are no longer covered by that carrier.

Non-Direct Patient Care
Services that are not considered direct patient care, telemedicine or telehealth, 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 Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail

exchanges).

Obesity or Weight Reduction/Control
Medical treatment, medications, surgical treatment (including revisions, reversals, and treatment of complications), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions, except to the extent Covered Services are required as part of the USPSTF, HRSA, or CDC requirements.

Orthognathic Surgery
Services and supplies for orthognathic surgery not required due to temporomandibular joint disorder, Injury, sleep apnea or congenital anomaly. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes and therapy or service animals, including the cost of training and maintenance.

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 Member'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.

Riot, Rebellion, War and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Member's **voluntary participation in** a riot, war, armed invasion or aggression, insurrection or rebellion or sustained by a Member arising directly from an act deemed illegal by an officer or a court of law.

Routine Foot Care

Routine Hearing Exam

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-medical self-care, training programs, including:

- childbirth-related classes including infant care; and
- instructional programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

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 share 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 for Administrative or Qualification Purposes
Physical or mental examinations and associated services, such as laboratory or similar tests, 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 other institution; athletic training evaluation; legal proceedings, such as establishing paternity or custody; qualification for employment, marriage, insurance, occupational injury benefits, licensure or certification; or immigration or emigration.

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

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. For purpose of this exclusion, "maternity and related medical services" includes otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Refer to the Maternity Care and/or Right of Reimbursement and Subrogation Recovery sections for more information.

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

Travel and Transportation Expenses
Travel and transportation expenses when the transportation is for personal or convenience purposes, except for travel expenses specified under the Gene Therapy and Adoptive Cellular Therapy benefit.

Varicose Veins Treatment
Treatment of varicose veins, except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins.

Vision Care
Routine eye exam, 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
Expenses for services and supplies incurred as a result of any work-related Illness or Injury, including any claims that are resolved related to a disputed claim settlement. We may require You or one of Your eligible dependents to file a claim for workers' compensation benefits before providing any benefits under this coverage. The only exception is if You or one of Your eligible dependents are exempt from state or federal workers' compensation law. If the entity providing workers' compensation coverage denies Your claims and You have filed an Appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Right of Reimbursement and Subrogation Recovery provision.

Contract and Claims Administration

This section explains administration of benefits and claims, including situations when Your health care expenses are the responsibility of a source other than Us.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims payment is due, We decide whether We will pay the Member, the Provider and Member jointly, or the Provider directly, subject to any legal requirements.

In-Network or Contracted Provider Claims and Reimbursement

You must present Your Member card to an In-Network or Contracted Provider and furnish any additional information requested. The Provider will give Us the information We need to process Your claim.

We will pay an In-Network Provider 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.

Out-of-Network Provider Claims and Reimbursement

In order for Us to pay for Covered Services, You or the Out-of-Network Provider must first send Us 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 Us 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.

Our standard policy is to make payment for Out-of-Network Provider claims on joint payee checks issued to both the Member and the Provider or, with submission of sufficient documentation that the Member has already "paid in full," on checks issued solely to the Member. However, in some situations, We choose to pay the Out-of-Network Provider directly by check issued solely to the Provider.

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

Timely Filing of Claims

You must provide written proof of loss within one year after the date of service of the claim. If You can show that it was not reasonably possible to provide such proof and that such proof was provided as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. We will deny a claim that is not filed in a timely manner unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may appeal a denial in order to demonstrate that the claim could not have been filed in a timely manner, as outlined in the Appeal process.

Ambulance Claims

When You or Your Provider submits a claim for ambulance services, it must show the location the patient was picked up from and the facility where he or she was taken. It should also show the date of service, the patient's name and the patient's group and identification numbers.

Claims Determinations

Within 30 days of Our receipt of a claim, We will notify You of Our action. However, this 30-day period may be extended by an additional 15 days when We cannot take action on the claim due to lack of information or extenuating circumstances. We will notify You of the extension within the initial 30-day period and provide an explanation why the extension is necessary. If We require additional information to process the claim, We must allow You at least 45 days to provide it to Us. If We do not receive the

requested information within the time We have allowed, We will deny the claim.

OUT-OF-AREA SERVICES

We have 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 We serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of Our Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("nonparticipating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of providers.

BlueCard Program

Under the BlueCard Program, when You receive Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You access Covered Services outside Our Service Area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for Your claim because they will not be applied after a claim has already been paid.

Value-Based Programs

If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

For the purpose of this section, the following definitions apply.

- Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.
- Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- A Care Coordination Fee is a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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

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

Nonparticipating Providers Outside Our Service Area

- Your Liability Calculation. When Covered Services are provided outside of Our Service Area by

nonparticipating Providers, the amount You pay for such services will normally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for nonparticipating emergency services.

- Exceptions. In certain situations, We may use other payment methods, such as billed covered charges, the payment We would make if the health care services had been obtained within Our Service Area, or a special negotiated payment to determine the amount We will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States You may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered health services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists You with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the United States, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or hospital) outside the United States, 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, will arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient providers located outside the United States will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for covered healthcare services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from Us, the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your 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.

CLAIMS RECOVERY

If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right, at Our discretion, to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Enrolled Employee or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

We regularly work 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.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to Your Group's experience or the experience of the pool under which You or Your Group is rated. Crediting reduces

claims expense and helps reduce future premium rate increases.

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

This section explains how We treat various matters having to do with administering Your benefits and/or claims, including situations that may arise in which Your health care expenses are the responsibility of a source other than Us.

As used herein, the term "Third Party" means any party that is, or may be, or is claimed to be, responsible for Illness or Injuries to You. Such Illness or Injuries are referred to as "Third Party Injuries." Third Party includes any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries.

If this plan pays benefits under this Booklet to You for expenses incurred due to Third Party Injuries, then We retain the right to repayment of the full cost, to the extent permitted by law of all benefits provided by this plan on Your behalf that are associated with the Third Party Injuries. Our rights of recovery apply to any recoveries made by or on Your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate You for Injuries resulting from an accident or alleged negligence.

By accepting benefits under this plan, You specifically acknowledge Our right of subrogation. When this plan pays health care benefits for expenses incurred due to Third Party Injuries, We shall be subrogated to Your right of recovery against any party to the extent of the full cost, to the extent permitted by law of all benefits provided by this plan. We may proceed against any party with or without Your consent.

By accepting benefits under this plan, You also specifically acknowledge Our right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to Third Party Injuries and You or Your representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate You for Third Party Injuries. By providing any benefit under this Booklet, We are granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent permitted by law of the full cost of all benefits provided by this plan. Our right of reimbursement is cumulative with and not exclusive of Our subrogation right and We may choose to exercise either or both rights of recovery.

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.

We will not exercise Our rights of recovery and subrogation until You have been fully compensated for Your loss and expense incurred.

This provision applies when You incur health care expenses in connection with an Illness or Injury for which one or more third parties is responsible. In that situation, benefits for otherwise Covered Services are excluded under this Contract to the extent You receive a recovery from or on behalf of the responsible third party in excess of full compensation for the loss. If You do not pursue a recovery of the benefits We have advanced, We may choose, in Our discretion, to pursue recovery from another responsible party, including automobile medical no-fault, personal injury protection ("PIP") carrier on Your behalf.

Here are some rules which apply in these Third-Party liability situations:

- By accepting benefits under this plan, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by You.
- You or Your representative agrees to cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Booklet. In addition, You or Your representative agrees to do nothing to prejudice Our subrogation and reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible third party, We may advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the third party in trust for Us, up to the amount of benefits We paid in connection with the Illness or Injury.
- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to the plan's right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- Further, You or Your representative give Us a lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by law to the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- You or Your representative also agrees to pay from any recovery, settlement, judgment or other source of compensation, any and all amounts due Us as reimbursement for the full cost of all benefits, to the extent permitted by law, associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Injury or Illness through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which We have provided benefits. This is true regardless of whether:

    - the Third Party or the Third Party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the Third-Party recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Contract. The amount to be held in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.

- Any benefits We advance are solely to assist You. By advancing such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

We may recover to the extent permitted by law, the full cost of all benefits paid by this plan under this Booklet without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. You may incur attorney's fees and costs in connection with obtaining recovery. If this plan is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this plan is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. In the event You or Your representative fail to cooperate with Us, You shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Us in obtaining repayment.

No-Fault Coverage

This provision applies when You incur health care expenses in connection with an Illness or Injury for which no-fault coverage is available. In that situation, benefits for otherwise Covered Services are

excluded under this Contract to the extent Your expenses for services and supplies have been covered or have been accepted for coverage by a no-fault carrier.

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorist insurance. When We use the term motor vehicle insurance below, it includes medical expense coverage, personal injury protection coverage, uninsured motorist coverage, underinsured motorist coverage or any coverage similar to any of these coverages. Benefits for health care expenses are excluded under this Contract if You receive payments from uninsured motorist coverage or underinsured motorist coverage for such expenses to the extent those payments exceed the amount necessary to fully compensate You, along with all other payments You receive to compensate You for Your Injuries, losses or damages, for those Injuries, losses or damages.

Here are some rules which apply with regard to motor vehicle insurance coverage:

- If a claim for health care expenses arising out of a motor vehicle accident is filed with Us and motor vehicle insurance has not yet paid, We may advance benefits for Covered Services as long as You agree in writing:
  - to give Us information about any motor vehicle insurance coverage which may be available to You; and
  - to otherwise secure Our rights and Your rights.
- If We have paid benefits before motor vehicle insurance has paid, We are entitled to have the amount of the benefits We have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of You held in trust for Us. The amount of benefits We are entitled to will never exceed the amount You receive from all insurance sources that fully compensates You for Your loss and We will only seek to recover amounts You have received from other insurance sources to the extent those amounts exceed full compensation to You for Your Injuries, losses or damages.
- You may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the Right of Reimbursement and Subrogation Recovery provision apply. However, We will not seek double reimbursement.

Workers' Compensation

This provision applies if You have filed or are entitled to file a claim for workers' compensation. Benefits for treatment of an Illness or Injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Contract. The only exception would be if You or one of Your eligible dependents are exempt from state or federal workers' compensation law.

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

- You must notify Us in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.
- If the entity providing workers' compensation coverage denies Your claims and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Right of Reimbursement and Subrogation Recovery provision.

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining recovery. If this plan is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this plan is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan. This section is a summary of only a few of the provisions of Your health plan to help You understand COB, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in Your Contract, which determines Your benefits.

Coordination of benefits is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common situations. If Your situation is not described, read Your Contract or contact the Washington State Insurance Department.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have Family coverage through both employers. When You are covered by more than one health plan, Washington state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each health plan should pay when You have a claim. The goal is to ensure that the combined payments of all plans do not add up to more than Your covered health care expenses.

Primary or Secondary?

You will be asked to identify all the plans that cover members of Your Family. 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. We need this information to determine whether We are the "primary" or "secondary" benefit payer. The primary plan always pays first when You have a claim. Any plan that does not contain Your state's COB rules will always be primary.

When This Plan is Primary

If You or a family member is covered under another plan in addition to this one, We will be primary when:

- **Your Own Expenses.** The claim is for Your own health care expenses, unless You are covered by Medicare and both You and Your spouse are retired.
- **Your Spouse's Expenses.** The claim is for Your spouse, who is covered by Medicare, and You are not both retired.
- **Your Child's Expenses.** The claim is for the health care expenses of Your child who is covered by this plan; and
    - You are married and Your birthday is earlier in the year than Your spouse's, or You are living with another individual (regardless of whether or not You have ever been married to that individual) and Your birthday is earlier in the year than that other individual's birthday. This is known as the "birthday rule"; or
    - You are separated or divorced, and You have informed us of a court decree that makes You responsible for the child's health care expenses; or
    - There is no court decree, but You have custody of the child.
- **Other Situations.** We will be primary when any other provisions of state or federal law require Us to be.

How We Pay Claims When We Are Primary

When We are the primary plan, We will pay the benefits according to the terms of the Contract, just as if You had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When We are knowingly the secondary plan, We will make payment promptly after receiving payment information from Your primary plan. As Your secondary plan, We may ask You and/or Your Provider for information in order to make payment. To expedite payment, be sure that You and/or Your Provider supply all required information in a timely manner.

If Your primary plan fails to pay within 60 calendar days of receiving all necessary information from You and Your Provider, You and/or Your Provider may submit the claim to Us as if We were the primary plan. In such situations, We are required to pay those claims within 30 calendar days of receiving Your claim and the notice that Your primary plan has not paid. **This provision does not apply if Medicare is the**

primary plan.

We may recover from the primary plan any excess amount paid under the Right of Recovery provision in the Contract.

- If there is a difference between the amounts the plans allow, We will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the amount called for in Our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their Providers as do some other plans.
- We will determine Our payment by subtracting the amount paid by the primary plan from the amount We would have paid if We had been the primary plan. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to 100% of the total allowable expense (the highest of the amounts allowed under each plan involved) for Your claim. We are not required to pay an amount in excess of Our maximum benefits, plus any accrued savings. If Your Provider negotiates reimbursement amounts with the plan(s) for the service provided, Your Provider may not bill You for any excess amounts once he or she has received payment for the highest of the negotiated amounts. When Our deductible is fully credited, We will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that We do not cover, We may pay for those expenses.

If You have questions about this Coordination of Benefits provision, contact the Washington State Insurance Department.

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under the Contract and wish to have it reviewed, You may Appeal. There is one level of Internal Appeal, as well as an External appeal with an Independent Review Organization You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section. For Grievances or complaints not involving an Adverse Benefit Determination, refer to the Grievance Process.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Appeals Coordinator at the Appeals address in the Introduction or by facsimile at 1 (888) 496-1542. Verbal requests can be made by calling Us.

Each level of Appeal, including Expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the first Internal level, within 180 days of Your receipt of Our original adverse decision that You are Appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement within 72 hours of receiving the request.

Upon request and free of charge, You, or Your Representative, have the right to review copies of all documents, records and information relevant to any claim that is the subject of the determination being appealed.

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 specifically request an Expedited Appeal. See Expedited Appeals later in this section for more information.

If We reverse Our initial Adverse Benefit Determination, which We may do at any time during the review process, We will provide You with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

If You request a review of an Adverse Benefit Determination, We will continue to provide coverage for disputed inpatient care benefits or any benefit for which a continuous course of treatment is Medically Necessary, pending outcome of the review. If We prevail in the Appeal, You may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law.

Internal Appeals

Internal Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are Appealing. You or Your Representative, on Your behalf, will be given a reasonable opportunity to provide written materials, including written testimony. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. If the Appeal involves a Post-Service investigational issue, a written notice of the decision will be sent within 20 working days after receiving the Appeal. For all other Appeals, the written notice will be sent within 14 days of receipt. You will be notified if, for good cause, We require additional time. An extension cannot delay the decision beyond 30 days without Your informed written consent.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available to You if the Appeal involves an Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria and only after You have exhausted the internal level of Appeal, or We have failed to provide You with an Internal Appeal decision within the requirements of the Internal Appeal process.

We coordinate voluntary External Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Appeal documentation, which is available to You or Your Provider upon request. You will also be provided 5 business days to submit additional written information directly to the IRO for consideration. A written notice of the IRO's decision will be sent to You within 15 days after the IRO

receives the necessary information or 20 days after the IRO receives the request. Choosing the voluntary External Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

The voluntary External Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with Us. This includes, but is not limited to, civil action under Section 502(a) of ERISA, where applicable.

EXPEDITED APPEALS

An Expedited Appeal is available if one of the following applies:

- You are currently receiving or are prescribed treatment for a medical condition; or
- Your treating Provider believes the application of regular Appeal time frames on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

You may request concurrent expedited internal and external reviews of Adverse Benefit Determinations (meaning the reviews will be done simultaneously). When concurrent expedited reviews are requested, We will not extend the timelines by making the determinations consecutively. The requisite timelines will be applied concurrently.

Internal Expedited Appeal

The internal Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. Internal Expedited Appeals are reviewed by employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. Reviewers will include an appropriate clinical peer in the same or similar specialty as would typically manage the case. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals time frame) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within 72 hours of the date of decision.

Voluntary Expedited Appeal - IRO

If You disagree with the decision made in the internal Expedited Appeal and You or Your Representative reasonably believes that preauthorization or concurrent care (Pre-Service) remains clinically urgent, You may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Appeal at the same time You request an Expedited Appeal from Us.

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Expedited Appeal documentation, which is available to You or Your Provider upon request. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of the IRO's receipt of the necessary information. This will be followed by written notification within 48 hours of the verbal notice. Choosing the voluntary Expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

The voluntary 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 with Us, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If You have any questions about the Appeal process outlined here, contact Customer Service or write to Customer Service at the Customer Service address in the Introduction.

ASSISTANCE

For assistance with internal claims and Appeals and the external review process, contact:

Office of the Insurance Commissioner
Consumer Protection Division

PO Box 40256
Olympia, WA 98504-0256
Toll Free: 1 (800) 562-6900
TDD: 1 (360) 586-0241
Olympia: 1 (360) 725-7080
Fax: 1 (360) 586-2018
E-mail: **cap@oic.wa.gov**
Web: **www.insurance.wa.gov**

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 a denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or 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.

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Representative, to change a previous decision made by Us concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Member and Us;
- rescissions of Your benefit coverage by Us; and
- other matters as specifically required by state law or regulation.

Expedited Appeal means an Appeal where:

- You are currently receiving or are prescribed treatment for a medical condition; and
- Your treating Provider believes the application of regular Appeal time frames on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

Experimental or Investigational means a Health Intervention that We have classified as Experimental or Investigational. For a full definition of Experimental and Investigational, refer to Experimental/Investigational in the Definitions section.

External Appeal means a review of an Adverse Benefit Determination performed by an Independent Review Organization to determine whether Our Internal Appeal decisions are correct.

Grievance means a written or oral complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary External Appeals and voluntary External Expedited Appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

Internal Appeal means a review and reconsideration of an Adverse Benefit Determination performed by Us.

Post-Service means any claim for benefits that is not considered Pre-Service.

Pre-Service means any claim for benefits which must be approved 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 Your personal 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 a Member who is an unmarried and dependent child and 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 without additional authorization. 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 be disclosed to You, Your personal Representative or treating Provider only.

Grievance Process

If You or Your Representative (any Representative authorized by You) has a complaint not involving an Adverse Benefit Determination and wishes to have it resolved, You may submit a Grievance to Us. Grievances may be submitted orally or in writing through either of the following contacts:

Call Customer Service at 1 (888) 367-2112 or write to Customer Service at the Customer Service address in the Introduction.

A Grievance may be registered when You or Your Representative expresses dissatisfaction with any matter not involving an Adverse Benefit Determination, including but not limited to Our customer service or quality or availability of a health service. Once received, Your Grievance will be responded to in a timely and thorough manner. Grievances will also be collectively evaluated by Us, on a quarterly basis, for improvements. If You would like a written response or acknowledgement of Your Grievance from Us, request at the time of submission.

For any complaints involving an Adverse Benefit Determination, refer to the Appeals Process section within this Booklet.

DEFINITIONS SPECIFIC TO THE GRIEVANCE 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 a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's or applicant'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.

Grievance means a written or oral complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

Who Is Eligible, How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment, or during an annual enrollment period. It describes when coverage under the Contract begins for You and/or Your eligible dependents, though payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE, 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 Group and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

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 enrollment period to enroll.

Employees

You become eligible to enroll in coverage on the date You have worked for the Group long enough to satisfy any required probationary period.

Dependents

Your Enrolled Dependents are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when We have enrolled them in coverage under the Contract. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your registered domestic partner or non-registered domestic partner for whom You have submitted an accurate and complete affidavit of qualifying domestic partnership.
- 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 physical handicap that began before his or her 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
    - he or she is an enrolled child immediately before his or her 26th birthday; or
    - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site or by calling Our Customer Service department. We may request updates on the child's disability or handicap at reasonable times as We consider necessary (but this will not be more often than annually following the dependent's 28th birthday).

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a non-registered domestic partner, an affidavit of qualifying domestic partnership form) to Us. 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 if payment of additional premium is required to provide coverage for the child. Application for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's

attaining eligibility. 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, if any associated additional premium has been paid within 60 days 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, the Effective Date is the first day of the month following receipt of the application for enrollment.

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

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 enrollment period.

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

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll for coverage under the Contract within 30 days from the date of the qualifying event (except that where the qualifying event is involuntary 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):

- 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 instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours, or meeting or exceeding the lifetime limit on all benefits on a former plan.
- You and/or Your eligible dependent lose coverage due to no longer residing, living, or working in the service area of that coverage (and, if the coverage is in the group market, no other benefit package was available through the sponsoring entity).
- 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).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the day after the prior coverage ended.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 30 days from the date of the qualifying event (except that, where the qualifying event is You and/or Your dependent(s) becoming eligible for premium assistance under Medicaid or Children's Health Insurance Program (CHIP), or the Washington State Department of Social and Health Services (DSHS) determination that it is cost-effective for an eligible dependent to have coverage under the Contract, You have 60 days from the date of the qualifying event to enroll):

- You marry or begin a domestic partnership; or
- You acquire a new child by birth, adoption, or Placement for Adoption.

If You are already enrolled or if You declined coverage when first eligible and subsequently have the following qualifying event, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll for coverage under the Contract within 60 days from the date of the qualifying event:

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

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where the qualifying event is a child's birth, adoption, or Placement for Adoption, coverage is effective from the date of the birth, adoption or placement.

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the period of time before the Group's Renewal Date and 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 (and, in the case of a non-registered domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

When Group Coverage Ends

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. You must notify Us within 30 days of the date on which an Enrolled Dependent is no longer eligible for coverage.

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

CONTRACT TERMINATION

If the Contract is terminated or not renewed by the Group or Us, coverage ends for You and Your Enrolled Dependents on the date the Contract is terminated or not renewed.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the last day of the month in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the COBRA and Non-COBRA 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 Contract, coverage will end for You and all Enrolled Dependents on the last day of the month in which eligibility ends.

NONPAYMENT OF PREMIUM

If You fail to make required timely contributions to premium, coverage will end for You and all Enrolled Dependents.

FAMILY AND MEDICAL LEAVE

If Your Group grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - to care for Your newly born child;
    - to care for Your spouse, domestic partner, child, or parent with a serious health condition;
    - the placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or Mental Health Condition.

During the FMLA leave, You must continue to pay the monthly premium through the Group on time. The provisions described here will not be available if the Contract terminates.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the FMLA leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits

described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for COBRA continuation. However, a person who does not return to active employment following FMLA 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 FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Group must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your Group, You can continue coverage for up to three months. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

A leave of absence is an employer-granted period off work made at Your request, during which You are still considered to be employed and are carried on the Group's employment records. A leave can be granted for any reason acceptable to the Group. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Contract only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave. If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Enrolled Dependents) may reenroll under the Contract only during the next annual enrollment period.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the month in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the continuation of coverage provisions.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the month following the date a divorce or annulment is final.

Death of the Enrolled Employee

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

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (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 domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) 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 parties to the domestic partnership enter into a marriage (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage).

Loss of Dependent Status

- Eligibility ends on the last day of the month in which an enrolled child exceeds the dependent age limit.
- An enrolled child will also lose eligibility on the date the child is removed from placement if there is a disruption of placement before legal adoption.

OTHER CAUSES OF TERMINATION

Members may be terminated for any of the following reasons. However, it may be possible to continue coverage under the Contract according to the COBRA and Non-COBRA Continuation of Coverage

provisions.

Fraudulent Use of Benefits

If You or Your Enrolled Dependent 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 Contract will terminate for that Member.

Fraud or Misrepresentation in Application

We have issued the Contract in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding a Member (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Group), We will take any action allowed by law or Contract, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups. If Your Group is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

- 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;
- You become entitled to Medicare benefits; or
- Your enrolled child loses eligibility as a child under this coverage.

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. (A special COBRA continuation also applies to You and Your Enrolled Dependents under certain conditions if You are retired and Your Group files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules

Generally, You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent. In order to preserve Your and Your Enrolled Dependent's rights under COBRA, You or Your Enrolled Dependents must inform the Group in writing within 60 days of:

- Your divorce, annulment, termination of registered or non-registered domestic partnership, or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Enrolled Dependent were disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Enrolled Dependent is no longer disabled for Social Security purposes, You or Your Enrolled Dependent must provide the Group notice of that determination within 30 days of the date it is made.)

The Group also must meet certain notification, election and payment deadline requirements. It is very important that You keep the Group informed of the current address of all Members who are or may become qualified beneficiaries.

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends.

Notice

The Contract includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your Group.

After You and/or Your Enrolled Dependents exhaust COBRA continuation coverage, an individual policy may be available.

Non-COBRA Continuation of Coverage

You and Your Enrolled Dependents are entitled to continuation of Group coverage benefits upon loss of eligibility for coverage.

The Group must notify You and Your Enrolled Dependents of this continuation right. If You and/or Your Enrolled Dependents do not receive notice, You may contact Us directly within 60 days following termination of coverage and elect continuation of coverage.

If You and/or Your Enrolled Dependents choose to continue coverage under this right, You must enroll in writing and pay the premium for such coverage within 60 days of coverage termination. You will be required to make timely premium payments to the Group. The Group may charge You and Your Enrolled Dependents a premium no higher than the current rate paid for coverage of a comparable Member (or Members) who lost coverage and the Group is not required to make any contribution toward premiums for continuation coverage. Where an enrollment form and premium are received within the 60-day period, the accepting Member's coverage continues, without interruption, from the date the Member's coverage was terminated.

This continuation of coverage will terminate when the first of the following occurs:

- You and/or Your Enrolled Dependents fail to make payment of premiums for the coverage to the Group within its established time frame;
- six months of coverage has elapsed from the effective date of continuation coverage; or
- the Group's coverage is terminated.

If the Group replaces coverage with a similar plan, those who have continued coverage may obtain coverage under the replacement policy for the balance of the period that they would have been allowed to extend benefits under the replaced coverage.

If Your Group is required to offer COBRA continuation of coverage, You may continue group coverage under both COBRA and this non-COBRA continuation of coverage. In almost all cases, COBRA offers greater benefits with fewer restrictions than this continuation of coverage. However, administration will be according to whichever law offers the greatest benefit to You. The maximum number of months You may continue coverage will never be more than the number available under COBRA.

After You and/or Your Enrolled Dependents exhaust non-COBRA continuation coverage, an individual policy may be available.

Conversion

When eligibility under the Contract terminates, You will be allowed to enroll under one of Our conversion plans if You are under age 65 and ineligible for Medicare.

We must receive Your application for one of Our conversion plans within 31 days following termination of coverage under this Contract. You will not be required to complete a health statement. Conversion plan benefits will be the standard individual medical and Hospital benefits coverage in effect at the date of conversion that We customarily offer to Members upon termination of coverage. Rates under the conversion plan will likely be higher than this Contract and benefits will likely be substantially less. Additional information is available by calling Customer Service.

If the Contract with the entire Group terminates and the Group transfers its health care plan to another Contract with Us, to another carrier or to a self-funded plan and You are covered under that plan, this conversion option does not apply.

Other Continuation Options

This section describes situations when coverage may be extended for You and/or Your Enrolled Dependents beyond the date of termination.

Medicare Supplement or Individual Contract

When eligibility under the Contract terminates, You may be eligible for coverage under an individual insurance policy or a Medicare supplement plan through Us. Additional information is available by contacting Customer Service.

- If You are eligible for Medicare, You may be eligible for coverage under one of Our Medicare supplement plans. To be eligible for continuous coverage, We must receive Your application within 31 days following Your termination from the Contract. If You apply for a Medicare supplement plan within six months of enrolling in Medicare Part B coverage, We will not require a health statement. After the six-month enrollment period, We may require a health statement. Benefits and premiums under the Medicare supplement plan will be substantially different from the Contract.
- If You are not eligible for Medicare, You may be eligible for coverage under one of Our individual plans. Benefits and premiums under the individual plan may be substantially different from the Contract.

If the Contract with the entire Group terminates and the Group transfers its health care plan to another Contract with Us, to another carrier or to a self-funded plan and You are covered under that plan, this continuation option does not apply.

Strike, Lockout or Other Labor Dispute

If the Enrolled Employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, the Enrolled Employee may continue coverage under the Contract for himself or herself and Enrolled Dependents during the dispute for a period not exceeding six months, by paying the necessary premiums for Your coverage through the Group. This provision will not apply if the Enrolled Employee and Enrolled Dependents are eligible for COBRA.

If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full premium, including any part usually paid by the Group, directly to the union or trust that represents You. And the union or trust must continue to pay Us the premiums according to the Contract. This six months of continued coverage is instead of and not in addition to any continuation of coverage provisions of the Contract.

General Provisions and Legal Notices

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

CHOICE OF FORUM
Any legal action arising out of the Contract must be filed in a court in the state of Washington.

ERISA (IF APPLICABLE)
This provision applies if the Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

The Group intends that the Contract be maintained for the exclusive benefit of the employees and intends to continue this coverage indefinitely, but the Group reserves the right to discontinue or change this coverage at any time. If the Group terminates the Contract for any reason and does not replace the coverage with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

Rights and Protection
Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.

Duties
In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to Appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee submits a written request for certain materials from the plan administrator and does not receive the materials within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay the employee up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

Denied Claims
If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a Washington state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting his or her rights, employees may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, he or she should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

GOVERNING LAW AND BENEFIT ADMINISTRATION

The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Washington without regard to its conflict of law rules. We are not the plan administrator, but are a health care service contractor that provides health care coverage to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Member rights under this benefit plan that include the right to appeal, review by an Independent Review Organization and civil action.

GROUP IS AGENT

The Group is Your agent for all purposes under the Contract and not Our agent. You are entitled to health care benefits pursuant to an agreement between Us and the Group. In the Contract, the Group agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Contract. You, through the enrollment form signed by the Enrolled Employee, and as beneficiaries of the Contract, acknowledge and agree to the terms, provisions, limitations and exclusions in this Booklet.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Since We do not provide any health care services, We 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 neither Our employees nor agents. We are responsible for the quality of health care You receive only as provided by law. In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Booklet by reason of epidemic, disaster or other cause or condition beyond Our control.

MODIFICATION OF CONTRACT

We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until a minimum of 30 days (or as required by law) after written notice has been given to Members or to the Group. The modification must be uniform within the product line and at the time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract. No modification or amendment of the Contract will affect the benefits of any Member who is, on the Effective Date of such modification or amendment, confined in a Hospital or other facility on an inpatient basis, until the first discharge from such facility occurring after such Effective Date.

NO WAIVER

The failure or refusal of either party to demand strict performance of the Contract 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 Contract will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

NONASSIGNMENT

Only You are entitled to benefits under the Contract. These benefits are not assignable or transferable 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 Us. 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 Members or to the Group required in the Contract will be considered properly given if written

notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to Our Customer Service address; however, any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

NOTICE OF PRIVACY PRACTICES

We have a Notice of Privacy Practices that is available by calling Customer Service or visiting Our Web site.

PREMIUMS

Premiums are to be paid in advance to Us by the Group, on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's or Member's coverage on the last day of the month through which premiums are paid or such later date as is provided by applicable law.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Members expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group 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 Us to use the Blue Shield Service Mark in the state of Washington, for those counties designated in Our Service Area, and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract 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 Group or the Members for any of Our obligations to the Group or the Members created under the Contract. 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 Contract.

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 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 Us. This information will be used in accordance with Our Notice of Privacy Practices. To request a copy, visit Our Web site or contact Customer Service.

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 Us 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.

We are required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting Our Web site or contacting Customer Service.

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

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. Specific authorization will be obtained from You in order for Us to receive information related to these health conditions.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under the Contract, 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 of the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person for the current month has been paid by the Group on a timely basis.

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

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, We will provide coverage (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. Other terms are defined where they are first used.

PROVIDER DEFINITIONS

For Providers of care, we use the following terms:

Contracted Provider means a Provider that has a contract with Us or whose contract We may access through a network leasing agreement. These Providers may or may not be in Your network.

In-Network Provider means a Contracted Provider that is in Your Provider Network. Your Provider Network is: Preferred. In-Network Providers will not bill You for the amount above the Allowed Amount for a Covered Service. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, In-Network Providers include only Our identified Centers of Excellence for the particular therapy.

Non-Contracted Provider means a Provider that does not have a contract with Us or whose contract cannot be accessed through a network leasing agreement. If a Covered Service is provided by a Non-Contracted Provider, the Provider may bill You the amount above the Allowed Amount.

Out-of-Network Provider means Providers that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Out-of-Network Providers include any Provider that is not one of Our identified Centers of Excellence for the particular therapy.

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

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, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or 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.

GENERAL DEFINITIONS

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as full payment for a service or supply.
- For Out-of-Network Providers, the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges, as determined by Us 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 Us.

Ambulatory Surgical Center means a distinct facility or that portion of a facility licensed by the state in which it is located, that operates primarily to provide specialty or multispecialty 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.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us.

Calendar Year means the period from January 1 through December 31 of the same year; however, the

first Calendar Year begins on the Member's Effective Date.

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

Custodial Care means care for 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 to separate the patient from others or prevent 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.

Effective Date means the date specified by Us, following Our receipt of the enrollment form, as the date coverage begins for You and/or Your dependents.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so 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 Member's health, or with respect to a pregnant Member, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

Enrolled Employee means an employee of the Group who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage.

Experimental/Investigational means a Health Intervention that We have classified as Experimental or Investigational. We 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 Our 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. Contact Us by calling Customer Service or visit Our Web site 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 are intended to cover room and board, building, electronic medical records systems, billing, and other administrative or operational expenses.

Family means an Enrolled Employee and his or her Enrolled Dependents.

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. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

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.

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 inflicted 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 Member is covered under the Contract (which may include more than one coverage) through the Group with Us.

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 to prevent, evaluate, diagnose or treat 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. (If "Medically Necessary" or "Medical Necessity" is specifically defined in any benefit under the Medical Benefits section, such definition shall be applicable for purposes of that benefit instead of this definition.)

Member means an Enrolled Employee or an Enrolled Dependent.

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.

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 We have 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.

For more information call Us at 1 (888) 367-2112 or You can write to Us at 1800 Ninth Avenue, WA, 98101

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