2027 BOOKLET FOR:

[GROUP NAME]

[Plan Name]

Group Number: [Group Number]

Asuris Northwest Health Medical Benefits



NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages.

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

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

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-232-8229, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@asuris.com

Medicare Customer Service
Phone: 1-866-749-0355 (TTY: 711)
Email: medicareappeals@asuris.com

VSP Customer Service
Phone: 1-844-299-3041, (TTY: 711)

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

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

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

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

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-232-8229 (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 1-888-232-8229 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-232-8229 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-232-8229 (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 1-888-232-8229 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-232-8229 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-232-8229 (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。1-888-232-8229 (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' hódíilnih 1-888-232-8229 (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 1-888-232-8229 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-232-8229 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-232-8229 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-232-8229 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-232-8229 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-232-8229 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-232-8229 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-232-8229 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-232-8229 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi balloojima to ekkitaaki wolde caahu. Noddu 1-888-232-8229 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-232-8229 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-232-8229 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-232-8229 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-232-8229 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-232-8229 (رقم هاتف الصم والبكم TTY: 711)

SCHEDULE OF BENEFITS

Asuris Bronze HSA 6500 RealValue

This Schedule of Benefits provides information regarding Your cost-shares for Covered Services and how Provider choice affects Your out-of-pocket expenses. This Schedule of Benefits is part of Your Booklet. Read the entire Booklet to understand the benefits, limitations, exclusions, defined terms and provisions of Your coverage.

	Member Responsibility
	In-Network Provider Only
Coinsurance	50%
Deductible per Calendar Year • Except as noted with "Deductible waived," all benefits are subject to the Deductible and the Deductible must be met before benefits begin for any Member. However, the entire Deductible must be met before benefits begin for any Member of the Family.	$6,500 Single Coverage $13,000 Family Coverage
Out-of-Pocket Maximum per Calendar Year • The Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed $8,300. If a Member reaches this maximum amount prior to satisfying the Family Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for that Member for the remainder of the Calendar Year.	$8,300 Single Coverage $16,600 Family Coverage

YOUR PROVIDERS AND OUT-OF-POCKET EXPENSES

To receive benefits for Covered Services, this plan requires You see Providers that are in Your network (In-Network Providers). A list of In-Network Providers is available on Our website or You may also call Us to verify that Your Provider is an In-Network Provider. Services received from Providers outside of Your network (Out-of-Network Providers) will not be covered except for Ambulance and Emergency Room services.

This plan uses the following networks:

RealValue medical network
Choice Network vision network
Participating Dental Network

The Service Area for this plan is Adams, Asotin, Benton, Chelan, Douglas, Ferry, Franklin, Grant, Garfield, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, and Whitman Counties in the state of Washington.

A Primary Care Provider (PCP) is a doctor of medicine (M.D.) or doctor of osteopathy (D.O.), or doctor of naturopathy (N.D.) who has one or more of the following specialty types:

- general practice;
- family practice;
- internal medicine;
- pediatrics;

- geriatrics;
- obstetrics;
- gynecology;
- OB/GYN;
- preventive medicine;
- adult medicine;
- naturopathy; or
- women's health.

A PCP also includes any physician assistant, nurse practitioner, or advanced registered nurse practitioner, if their primary specialty is one of the above and they are operating within the scope of their license.

A Specialist is a Physician, Practitioner or urgent care center that does not otherwise meet the definition of a PCP.

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility**
	In-Network Provider Only
Preventive Care and Immunizations	0%, Deductible waived
Preventive Care – Expanded Immunizations	50%
Office or Urgent Care Center Visits – Illness or Injury • Outpatient services and supplies (not billed as an office visit) provided by an urgent care center are covered.	PCP – 50% Specialist (including urgent care) – 50%
Other Professional Services	50%
Acupuncture	50%
Ambulance Services • Out-of-Network services are covered and apply to the Deductible and In-Network Out-of-Pocket Maximum.	50%
Blood Bank	50%
Dental Hospitalization	50%
Diabetic Education	0%
Dialysis	50%
Durable Medical Equipment	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility** **In-Network Provider Only**
Emergency Room • Out-of-Network services are covered and apply to the Deductible and In-Network Out-of-Pocket Maximum.	50%
Habilitation Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	50%
Hearing Instruments and Services • One hearing instrument per ear every 36 months	After IRS minimum deductible, 0%
Home Health Care • 130 visits per Calendar Year	50%
Hospice Care • 14 days for respite care per Lifetime	50%
Hospital Care – Inpatient and Outpatient	50%
Hospital Care – Ambulatory Surgical Center	40%
Infusion Therapy	50%
Maternity Care	50%
Medical Foods	50%
Mental Health Services	50%
Neurodevelopmental Therapy • 25 professional visits per Calendar Year	50%
Newborn Care	50%
Nutritional Counseling	50%
Orthotic Devices	50%
Palliative Care • 30 visits per Calendar Year	50%
Prosthetic Devices	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility** **In-Network Provider Only**
Radiology and Laboratory Services – Outpatient • Certain diagnostic and supplemental breast examinations are not subject to any cost-sharing when provided by In-Network Providers.	50%
Reconstructive Services and Supplies	50%
Rehabilitation Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	50%
Reproductive Health Care Services • Vasectomy and termination of pregnancy (see Reproductive Health Care Services in Your Booklet for more information) • All FDA-approved contraceptive drugs, devices, products and services.	After IRS minimum deductible, 0% for vasectomy and termination of pregnancy 0%, Deductible waived for all other FDA-approved contraceptive drugs, devices, products, and services
Skilled Nursing Facility • 60 inpatient days per Calendar Year	50%
Spinal Manipulations • 10 spinal manipulation visits per Calendar Year	50%
Substance Use Disorder Services	50%
Temporomandibular Joint (TMJ) Disorders	50%
Transplants	50%
Virtual Care – Store and Forward Services	50%
Virtual Care – Telehealth	50%

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility** **Participating Pharmacy Only**
No coverage for Prescription Medications not on the Drug List or Prescription Medications from a Nonparticipating Pharmacy. Your cost-sharing will be applied to the Deductible (if Deductible applies) and In-Network Out-of-Pocket Maximum. **Prescription Medications – from a Pharmacy** • Deductible waived for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section. • You are not responsible for any Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List. To obtain this list visit Our website or contact Customer Service. Contact Information is available in the Introduction Section. • Deductible waived when You fill prescriptions for insulin and covered diabetic supplies, and for certain inhaled asthma medication. • 90-day supply for Prescription Medications • 30-day supply for Specialty Medications • 90-day supply for Self-Administrable Injectable Medications • Cost-sharing for insulin and certain inhaled asthma medication will not exceed $35 per 30-day supply, and Your cost-share will be applied to the Deductible. • After IRS minimum deductible, cost-sharing for certain epinephrine autoinjectors (per 2-pack) will not exceed $35 per 30-day supply, and Your cost-share will be applied to the Deductible. • After IRS minimum deductible, You are not responsible for any cost-sharing for post-exposure prophylaxis (PEP) medications for the prevention of HIV	50% for each Preferred Generic Medication on the Drug List 50% for each Generic Medication on the Drug List 50% for each Preferred Brand-Name Medication on the Drug List 50% for each Brand-Name Medication on the Drug List 20% for each Preferred Specialty Medication on the Drug List from a Participating Specialty Pharmacy 50% for each Specialty Medication on the Drug List from a Participating Specialty Pharmacy

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility** **Participating Pharmacy Only**
from a Participating Pharmacy or when dispensed in an emergency room. • Up to a 12-month supply for refills of FDA-approved contraceptive drugs (may be dispensed on-site at a Provider's office, if available).	

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility** **Participating Pharmacy Only**
Prescription Medications – from a Home Delivery Supplier • 90-day supply for Self-Administrable Injectable Medications • 90-day supply for Prescription Medications • Cost-sharing for insulin and certain inhaled asthma medication will not exceed $105 per 90-day supply, and Your cost-share will be applied to the Deductible. • After IRS minimum deductible, cost-sharing for certain epinephrine autoinjectors (per 2-pack) will not exceed $105 per 90-day supply, and Your cost-share will be applied to the Deductible. • Up to a 12-month supply for refills of FDA-approved contraceptive drugs (may be dispensed on-site at a Provider's office, if available).	50% for each Preferred Generic Medication on the Drug List
	50% for each Generic Medication on the Drug List
	50% for each Preferred Brand-Name Medication on the Drug List
	50% for each Brand-Name Medication on the Drug List
Self-Administrable Cancer Chemotherapy Medications • 30-day supply	50% for each Preferred Generic and Generic Medication on the Drug List
	50% for each Preferred Brand-Name and Brand-Name Medication on the Drug List
	50% for each Preferred Specialty and Specialty Medication on the Drug List. Preferred Specialty or Specialty Medication must be provided by a Specialty Pharmacy.

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility** **VSP Doctor Only**
Pediatric Vision (under age 19) • 1 routine eye examination per Calendar Year • 1 frame per Calendar Year • 1 pair of lenses (2 lenses) per Calendar Year • Contacts may be selected (once per Calendar Year) instead of frames and lenses. • Low vision supplemental testing and supplemental aids every 2 Calendar Years • Additional limitations apply, refer to the Pediatric Vision Services Section.	Examination – 0%, Deductible waived
	Hardware – 0%, Deductible waived
	Contact Lens Evaluation and Fitting Examination – 0%, Deductible waived
	Low Vision Supplemental Testing – 0%, Deductible waived
	Low Vision Supplemental Aids – 0%, Deductible waived

Covered Services (per Member) Unless Otherwise Noted the Deductible Applies	
Benefit	**Member Responsibility** **In-Network Dentist Only**
Pediatric Dental (under age 19) • Additional limitations apply, refer to the Pediatric Dental Services Section.	Preventive and Diagnostic Services – 0%
	Basic Services – 20%
	Major Services – 50%
Dental4Health® • Benefit is for Members with qualifying medical conditions, refer to the Pediatric Dental Services Section. • Additional limitations apply, refer to the Pediatric Dental Services Section.	Cleanings, topical fluoride, oral examinations – 0%
	Periodontal maintenance, periodontal scaling and root planing, periodontal debridement – 0%

Introduction

Asuris Northwest Health

Street Address:
528 E. Spokane Falls Blvd., Suite 301
Spokane, WA 99202

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

This Booklet describes benefits effective **[{Month - spell out} dd, yyyy]**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the terms "We," "Us" and "Our" refer to Asuris Northwest Health and the term "Group" means the organization whose employees may participate in this coverage. References to "You" and "Your" refer to the Enrolled Employee and/or Enrolled Dependents. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

Notice of Privacy Practices: Asuris Northwest Health has a Notice of Privacy Practices that is available by calling Customer Service or visiting the website listed below.

ESSENTIAL HEALTH BENEFITS

This coverage complies with the essential health benefits in the following ten categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services (including behavioral health treatment);
- prescription drugs;
- rehabilitation and habilitation services and devices;
- laboratory services;
- preventive and wellness services;
- chronic disease management; and
- pediatric services including oral and vision care.

There is no annual or Lifetime maximum applicable to these services.

CONTACT INFORMATION

Customer Service: 1-888-367-2109
(TTY: 711)

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- to request a copy of Your identification card or print a copy via Our website if You have not received or have lost Your identification card;
- if You would like to request written or electronic information regarding any other plan that We offer;
- to talk with one of Our Customer Service representatives;
- to learn more about Gender Affirming Treatment or visit Our website at **asuris.com/member/lgbtq-support**;

- via Our website, **asuris.com**, to submit a claim online or chat live with a Customer Service representative; or
- for assistance in a language other than English.

Mail Your medical or pediatric dental claims to the following address:

P.O. Box 1106
Lewiston, ID 83501-1106

For questions about Your plan or to contact Us, Our Customer Service and correspondence address is:

P.O. Box 1106
Lewiston, ID 83501

Pediatric Vision Services – Vision Service Plan (VSP): 1-844-299-3041
(TTY: 711)

VSP phone lines are open Monday through Saturday, 6 a.m. to 5 p.m., Pacific time.

Contact VSP if You have Provider or benefit questions specific to Your pediatric vision coverage. You may also visit VSP's website at **vsp.com**.

Mail Your VSP Doctor vision claims to the following address:

Vision Service Plan
P.O. Box 495907
Cincinnati, OH 45249

For questions about Your vision coverage, write to VSP at the following address:

Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Case Management. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information refer to the Medical Benefits Section or call Case Management at 1-866-543-5765.

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 website at **asuris.com/web/asuris_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;
- a list of contracted health care benefit managers acting on Our behalf in the utilization of health care services;
- 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.

[Signature Graphic]
[Plan President Name]
[Plan President Title]
[Plan Name]

Using Your Booklet

ACCESSING PROVIDERS

For each benefit, We indicate in the Schedule of Benefits the Provider You may choose and Your payment amount for each provider option. See the Schedule of Benefits and the Definitions Section for a complete description of In-Network and Out-of-Network. You can go to **asuris.com** for further Provider network information.

If the Schedule of Benefits indicates that the plan provides benefits for the Covered Services of a Primary Care Provider (PCP), the following conditions apply:

- You may change the Provider of Your care (including primary care) at any time by consulting a different Provider.
- If We terminate the contract of Your PCP without cause, We will continue to cover Your PCP, on the same terms, for at least ninety days following notice of termination.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

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 website to help You navigate Your way through health care decisions. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR BOOKLET.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of this Booklet.

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

*Note 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. Services may be provided through third-party program partners who are solely responsible for their services. These program partners are not considered Providers under Your health plan.

Employee Wellness Reward

Employees and their enrolled spouse or domestic partner may each qualify for a $100 gift card reward per Contract Year. To qualify, You (the employee or the employee's enrolled spouse or domestic partner):

- Must have completed within the first three months of the Contract Year:
  - a Biometric Screening from an approved Provider;
  - Our General Health Assessment tool; and
- Must still be enrolled in the Group's health plan as of the later of the date of completion of the Biometric Screening and the date of completion of the General Health Assessment tool.

Biometric screening by a health care Provider can assist You in assessing Your health risks and identifying changes to improve Your health by providing information about Your blood pressure, cholesterol and body mass. Approved Providers for the Biometric Screening are identified on Our website or by contacting Customer Service.

A General Health Assessment is a tool You complete, describing Your health practices. The General Health Assessment is found online on Our website or by contacting Customer Service.

The Employee Wellness Reward is available to enrolled employees and their enrolled spouse or domestic partner.

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Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copays, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Schedule of Benefits and benefit sections in this Booklet to see what Your benefits are.

This is a high deductible health plan that may include "single" or "family" coverage.

Single Coverage means only one person has coverage. Examples include, but are not limited to:

- an employee who is the only one in their Family who has coverage;
- spouses who both work for the Group and have each filled out an application and are Enrolled Employees on separate coverages; or
- an Enrolled Dependent who is continuing insurance coverage on their own.

Family Coverage means two or more members of the same Family have the same coverage.

MAXIMUM BENEFITS

Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit has been reached. Any days, visits, services, or supplies that are applied toward any Deductible will be applied against the Maximum Benefit limit. Refer to the Schedule of Benefits to determine if a Covered Service has a specific Maximum Benefit.

You will be responsible for the total billed charges for Covered Services that are in excess of any Maximum Benefits. You will also be responsible for charges for any other services or supplies not covered by this plan, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before We will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. The Single Coverage Deductible is satisfied by a Member who is enrolled on Single Coverage.

The Family Coverage Deductible is satisfied when any combination of Family Members' payments total the Family Coverage Deductible amount.

We do not pay for services applied toward the Deductible. Refer to the Schedule of Benefits to see what Covered Services are subject to the Deductible. Except as specifically noted otherwise, any amounts You pay for non-Covered Services, Copays or amounts in excess of the Allowed Amount do not apply toward the Deductible. For additional information on how Prescription Medications apply to Your Deductible, refer to the Prescription Medications Section.

INTERNAL REVENUE SERVICE (IRS) MINIMUM DEDUCTIBLES UNDER HSA PLANS

As outlined in the Medical Benefits and Prescription Medications Sections, certain covered services are subject to the minimum deductible amounts permitted by the IRS on a high deductible health plan that qualifies for use with a health care savings account. For 2027, those amounts are $1,750 for Single Coverage and $3,500 for Family Coverage. Amounts You pay to satisfy the minimum deductible amount will also accrue to the overall plan Deductible. For more information visit Our website or contact Customer Service.

COINSURANCE (PERCENTAGE YOU PAY)

Your Coinsurance is the percentage You pay when Our payment is less than 100 percent. The Coinsurance varies, depending on the service or supply You received and who rendered it. Your Coinsurance applies once You have satisfied the Deductible for Covered Services up to any Maximum Benefit. Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. We do not reimburse Providers for charges above the Allowed Amount.

An In-Network Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible, Copay and/or Coinsurance amount. We generally do not cover services provided

by Out-of-Network Providers; when Out-of-Network Providers are eligible to provide Covered Services, however, Out-of-Network Providers may bill You for any balances over Our payment level in addition to the Deductible, Copay and/or Coinsurance amount. Those instances where You will not be balanced billed by Out-of-Network Providers are outlined in the Balance Billing provision below.

BALANCE BILLING

Balance billing occurs when You are billed for balances beyond any Deductible and/or Coinsurance for Covered Services provided to You by an Out-of-Network Provider when the Out-of-Network Provider's billed amount is not fully reimbursed by Us.

Federal and Washington State law protects You from being balance billed for certain services. You will not be balance billed by an Out-of-Network Provider for air ambulance services, emergency services, or for certain non-emergency surgical or ancillary services provided by an Out-of-Network Provider at an In-Network hospital or Ambulatory Surgical Center. Non-emergency surgical or ancillary services include anesthesiology, pathology, radiology, laboratory, hospitalist, or surgical services.

You are also protected from balance billing for ground ambulance services in the state of Washington, when provided by a Ground Ambulance Services Organization.

Any amounts You pay for ground or air ambulance services, emergency services, or for non-emergency surgical or ancillary services, as described above, will count toward Your Deductible and Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible and Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. The Single Coverage Out-of-Pocket Maximum is satisfied by a Member who is enrolled on Single Coverage.

The Family Coverage Out-of-Pocket Maximum is satisfied when any combination of Family Members' payments of their cost-shares for Covered Services total the Family Coverage Out-of-Pocket Maximum amount. No one Family Member may contribute more than the amount indicated for the Single Coverage Out-of-Pocket Maximum toward the Family Coverage Out-of-Pocket Maximum in a Calendar Year. A Family Member does not have to satisfy the Single Coverage Out-of-Pocket Maximum if the Family Coverage Out-of-Pocket Maximum has already been satisfied.

Any amounts You pay for non-Covered Services and amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. For additional information on how Prescription Medications apply to Your Out-of-Pocket Maximum, refer to the Prescription Medications Section. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach any applicable 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 Coinsurance does not change to a higher payment level or apply to the Out-of-Pocket Maximum for some benefits. Refer to the Schedule of Benefits to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

HOW CALENDAR YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Calendar Year.

The Contract is renewed each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. 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 Year. If the Deductible and/or Out-of-Pocket Maximum amounts increase during the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Contract during the same Calendar Year.

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

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

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

Medical Benefits

This section explains Your benefits for Covered Services. Referrals are not required before You can use any of the benefits of this coverage, including women's health care services. Nothing contained in this Booklet is designed to restrict Your choice of Provider for care or treatment of an Illness or Injury. All benefits are listed alphabetically, with the exception of Preventive Care and Immunizations, Office or Urgent Care Center Visits – Illness or Injury and Other Professional Services.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. Benefits for Gender Affirming Treatment are covered the same as any other Covered Services (to the extent such services are permitted under applicable law), regardless of an individual's sex assigned at birth, gender identity or expression. All covered benefits are subject to the limitations, exclusions, and provisions of this plan. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. 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 the types of Providers who deliver Covered Services.

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

Reimbursement may be available for new medical supplies, equipment, and devices You purchase from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. New medical supplies, equipment, and devices, such as a breast pump or wheelchair, purchased through an approved Commercial Seller are covered at the 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 website or contact Customer Service.

If You choose to access new medical supplies, equipment, and devices through Our website, 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.

CASE MANAGEMENT

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

PREAUTHORIZATION

We will not require preauthorization for emergency medical services, including admissions for emergency detoxification, or involuntarily committed mental health services provided by a state Hospital. No preauthorization is required for childbirth admissions, or admissions for newborns that need medical care at birth.

Some Covered Services may require preauthorization. Those services require contracted Providers to obtain preauthorization from Us before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from Us in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from Us prior to providing Covered Services. You may be responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, state and federal law, the Washington state Department of Health, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), including the Women's Preventive Services Initiative (WPSI) and the Bright Futures program, or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic, or other public health emergency, are covered for the following:

- routine physical examinations, well-baby care, women's care, and health screenings, including screening for:
  - gestational diabetes;
  - cervical cancer, including any necessary diagnostic testing as a result of an abnormal cervical cancer screening; and
  - obesity in patients ages six and older, and appropriate referrals to comprehensive, intensive behavioral interventions to promote improvements in weight status.
- intensive multicomponent behavioral interventions for weight management;
- Provider counseling and prescribed medications for tobacco use cessation;
- preventive breast cancer screenings, such as mammography services (including tomosynthesis);
- depression screening for all adults, including screening for maternal depression;
- immunizations for adults and children. We may cover immunizations in addition to those recommended by the organizations listed above, based upon reasonable scientific evidence and judgment from relevant expert organizations. Visit Our website or contact Customer Service to verify what immunizations are covered;
- breastfeeding support and one new non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from an In-Network 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, products and services (including vasectomy) as described under the Reproductive Health Care Services benefit.

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

For a complete list of services covered under this benefit, including information about how to access an approved Commercial Seller, obtaining a new 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 website or contact Customer Service. If You choose to access new medical supplies, equipment, and devices through Our website, 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, diagnostic colonoscopies or diagnostic mammograms) will be covered elsewhere in the Medical Benefits Section. In the event HRSA, USPSTF or the Centers for Disease Control and Prevention (CDC) adopt a new or revised recommendation, We have up to one year before coverage of the related services must be available and effective in this Booklet.

Expanded Immunizations

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Covered Services include immunizations for travel, occupation or residency in a foreign country. Contact Customer Service to verify what expanded immunizations are covered.

OFFICE OR URGENT CARE CENTER VISITS – ILLNESS OR INJURY

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

OTHER PROFESSIONAL SERVICES

Services and supplies provided by a professional Provider are covered, subject to any specified limits as explained in the following paragraphs:

Artificial Insemination

Services for artificial insemination, limited to simple preparation (sperm washing and isolation) and placement of sperm into cervix or uterus to achieve pregnancy.

Diagnostic Procedures

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

Medical Services and Supplies

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

Services and supplies also include:

- treatment of a congenital anomaly;
- Virtual Care service Facility Fees;
- Medically Necessary routine foot care, including, but not limited to, treatment of corns and calluses, trimming of nails, and foot care appliances for prevention of complications associated with a medical condition (for example, severe circulatory dysfunction or diminished sensation in the legs or feet); and
- blood banks.

Additionally, certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) are covered. Reimbursement for covered medical supplies may be available when these supplies are purchased new 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 website or contact Customer Service.

Professional Inpatient

Professional inpatient visits for treatment of Illness or Injury. Surgical or ancillary services (including anesthesiology, pathology, radiology, laboratory, or hospitalist services) provided by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center are covered at the In-Network benefit level. Contact Customer Service for further information and guidance.

Radiology and Laboratory

Diagnostic services and outpatient complex imaging for treatment of Illness or Injury. This includes Medically Necessary genetic testing, prostate screenings, and colorectal laboratory tests not covered under the Preventive Care and Immunizations benefit.

Diagnostic and supplemental breast examinations are also covered, including the following services:

- diagnostic mammography, including tomosynthesis;
- breast magnetic resonance imaging (MRI); and
- breast ultrasounds.

Diagnostic and supplemental breast examinations that meet the following criteria are not subject to any cost-sharing:

- diagnostic breast examinations used to evaluate an abnormality seen or suspected from a screening for breast cancer, or detected by another means of examination; and
- supplemental breast examinations used to screen for breast cancer when no abnormality is seen or suspected, based on personal or family medical history or additional factors that may increase the risk of breast cancer.

"Outpatient complex imaging" means:

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

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

Treatment of varicose veins is only covered when there is:

- active associated venous ulceration;
- objective documentation of persistent or recurrent bleeding from ruptured veins; or
- objective documentation of recurrent superficial phlebitis.

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

A selected list of Self-Administrable Injectable Medications is covered in the Prescription Medications Section.

ACUPUNCTURE
Acupuncture services provided by a Provider are covered.

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

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

APPROVED CLINICAL TRIALS
If an In-Network Provider is participating in an 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 an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Schedule of Benefits. Additional specified limits are as further defined.

Definitions
The following definitions apply to this Approved Clinical Trials benefit:

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

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

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

Routine Patient Costs means items and services that typically are Covered Services for a 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.

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

DIABETIC EDUCATION
Services and supplies for diabetic self-management training and education are covered, when provided by Providers with expertise in diabetes. Diabetic nutritional counseling and nutritional therapy are covered in the Nutritional Counseling benefit.

DIALYSIS
Services and supplies for outpatient and home dialysis are covered, including hemodialysis, peritoneal dialysis and hemofiltration. Dialysis received while inpatient is covered elsewhere in the Medical Benefits Section, such as the Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center benefit.

DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes (such as insulin pumps or continuous glucose monitors, and their supplies). Applicable sales tax for Durable Medical Equipment and mobility enhancing equipment is also covered.

Reimbursement may also be available for Durable Medical Equipment when purchased new 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. To find ways to access new Durable Medical Equipment, including how to access an approved Commercial Seller, visit Our website or contact Customer Service. If You choose to access new Durable Medical Equipment through Our website, 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)

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations and treatment, routinely available ancillary evaluative services and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized.

Post-exposure prophylaxis (PEP) medications are covered for the prevention of HIV for people at a high risk of infection after an exposure, as recommended by the CDC. You are not responsible for any Copay and/or Coinsurance for these PEP medications dispensed in an emergency room; however, these medications are subject to minimum deductible amounts as described in the Internal Revenue Service (IRS) Minimum Deductibles Under HSA Plans provision.

"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 Member, who is pregnant, to perform the delivery (including the placenta).

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. If services were not covered at the In-Network benefit level, contact Customer Service for further information and guidance.

HABILITATION SERVICES

Medically Necessary health care services and health care devices designed to assist a person to keep, learn or improve skills and functioning for daily living are covered. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and outpatient settings. Habilitation services also include manipulation of extremities. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, and vocational or custodial services are not classified as habilitative services and are not covered under this benefit.

Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Habilitation Services benefit limits.

HEARING INSTRUMENTS AND SERVICES

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

Diagnostic and hearing aid-related examinations, such as those to evaluate existing hearing loss or associated symptoms, are also covered.

Covered Services also include the following services for hearing instruments or for over-the-counter hearing aids:

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

Covered Services do not include:

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

Hearing instruments will be covered up to the In-Network benefit level, which is based upon the lesser of either the amount paid to an In-Network Provider for a Medically Necessary hearing instrument or the hearing instrument's retail market value. Coverage for specialty hearing instruments (e.g., with functionality beyond Medical Necessity) may be limited to the amount paid to an In-Network Provider for a Medically Necessary hearing instrument and You may be responsible for any excess costs above such amount.

HOME HEALTH CARE

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

Home health care furnished by duly licensed home health, hospice and home care agencies covered by this Booklet may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home health care:

- can be provided at equal or lesser cost;
- is the most appropriate and cost-effective setting; and
- is substituted with the consent of the Member and upon the recommendation of the Member's attending Physician or licensed health care Provider that such care will adequately meet the Member's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the individual Member. We may require a written treatment plan that has been approved by the Member's attending Physician or licensed health care Provider. Coverage of substituted home health care is limited to any Maximum Benefits available for hospital care or other inpatient care under this Booklet, and is subject to any applicable Deductible, Coinsurance, and Booklet limits.

HOSPICE CARE

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

Respite care is also covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Services and supplies of a Hospital or an Ambulatory Surgical Center (including Prescription Medications and services of staff Providers) are covered for treatment of Illness or Injury. 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. Please contact Customer Service for further information and guidance.

INFUSION THERAPY

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

MATERNITY CARE

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

Certain services such as screening for gestational diabetes, breastfeeding support, supplies (for example, a breast pump) and counseling are covered in the Preventive Care and Immunizations 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 this Booklet).

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. Refer to the Right of Reimbursement and Subrogation Recovery Section for more information.

Definitions

The following definitions apply 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

Medical foods for inborn errors of metabolism are covered, including, but not limited to, formulas for Phenylketonuria (PKU). Medically Necessary elemental formula is also 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

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

Additionally, applied behavioral analysis (ABA) therapy services are covered for treatment of autism spectrum disorders when Members seek services from Providers or licensed healthcare professionals qualified to prescribe and perform ABA therapy services under state law.

Definitions

The following definitions apply to this Mental Health Services benefit:

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

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

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

NEURODEVELOPMENTAL THERAPY

Neurodevelopmental therapy services by a Physician or Practitioner are covered. Such services must be to restore and improve function. Covered Services are limited to physical therapy, occupational therapy and speech therapy. Maintenance services are covered if significant deterioration of the Member's condition would result without the service.

NEWBORN CARE

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

NUTRITIONAL COUNSELING

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

ORTHOTIC DEVICES

Medically Necessary orthotics used to support, align or correct deformities or to improve the function of moving parts are covered, including, but not limited to:

- braces;
- splints;
- orthopedic appliances;
- orthotic supplies or apparatuses.

Reimbursement may also be available for new orthotic devices when purchased new from an approved Commercial Seller, even though that seller is not a Provider. Eligible new orthotic devices purchased

through an approved Commercial Seller are covered at the 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 website or contact Customer Service. If You choose to access new orthotic devices through Our website, 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.

We may elect to provide benefits for a less costly alternative item. Covered Services do not include:

- orthopedic shoes, regardless of diagnosis;
- Cosmetic items; and
- off-the-shelf shoe inserts.

Custom Orthotic Braces

Custom Orthotic Braces are covered per limb when Medically Necessary to perform physical activities and to complete activities of daily living or essential job-related activities. Covered Services also include:

- materials, components, and related services necessary to use devices for their intended purposes;
- instructions on using devices; and
- Medically Necessary repair or replacement.

“Custom Orthotic Brace” means an external medical device custom-fabricated or custom-fitted to support, correct, or alleviate neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity, is needed to improve the safety and efficiency of functional mobility, is patient-specific based on the patient's unique physical condition, and is deemed Medically Necessary for individuals with a mobility impairing health condition or disability.

PALLIATIVE CARE

Palliative care is covered when a Provider has assessed that a Member is in need of palliative services for a serious Illness (including remission support), life-limiting Injury or end-of-life care. "Palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living.

All other Covered Services for a Member receiving palliative care remain covered the same as any other Illness or Injury.

PREVENTIVE CARE FOR SPECIFIED CHRONIC CONDITIONS

Services and supplies are covered when used to treat a Member diagnosed with the associated chronic condition and prescribed to prevent either exacerbation of the chronic condition or the development of a secondary condition. Covered Services as specified below are not subject to any applicable Deductible for In-Network services:

- blood pressure monitor with a diagnosis of hypertension;
- hemoglobin A1c testing and retinopathy screening with a diagnosis of diabetes;
- International Normalized Ratio (INR) testing with a diagnosis of liver disease and/or bleeding disorder;
- Low-Density Lipoprotein (LDL) testing with a diagnosis of heart disease; or
- peak flow meter with a diagnosis of asthma.

PROSTHETIC DEVICES

Prosthetic Devices are covered to replace a missing body part, including, but not limited to:

- artificial limbs;
- mastectomy bras (only for Members who have had a mastectomy);
- external or internal breast prostheses following a mastectomy; and
- maxillofacial prostheses.

Covered Services also include:

- materials, components, and related services necessary to use devices for their intended purposes;
- instructions on using devices; and
- Medically Necessary repair or replacement.

“Prosthetic Device” means an external medical device that is used to replace or restore a missing limb or portion of a limb and is deemed Medically Necessary for an individual with a mobility impairing health condition or disability. Prosthetic Devices that are surgically inserted into the body are otherwise covered in the appropriate facility benefit.

RECONSTRUCTIVE SERVICES AND SUPPLIES

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

- 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

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness, Injury or disabling condition. "Rehabilitation services" mean physical, occupational, and speech therapy services necessary to help get the body back to normal health or function, and includes manipulation of extremities and associated services such as massage when provided as a therapeutic intervention.

Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Rehabilitation Services benefit limits.

REPRODUCTIVE HEALTH CARE SERVICES

Termination of pregnancy and related conditions are covered (to the extent such services are permitted under applicable law). All FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services are also covered, including, but not limited to:

- sterilization surgery (such as tubal ligation and vasectomy) and sterilization implants;
- implantable contraceptive devices, including insertion and removal, such as IUD copper, IUD with progestin, and implantable rods;
- contraceptive shots or injections;
- oral contraceptives (combined pill, extended/continuous use combined pill, and the mini pill);
- contraceptive products, such as condoms, vaginal rings, patches, diaphragms, sponges, cervical caps, and spermicide; and
- emergency contraceptives (such as levonorgestrel and ulipristal acetate).

We will cover up to a 12-month supply of FDA-approved contraceptive drugs from a Pharmacy or Home Delivery Supplier (may be dispensed on-site at a Provider's office, if available).

FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services are available without a prescription and no cost-sharing as explicitly described in both the Preventive Care and Immunizations benefit and the Covered Preventive Medications provision. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptive drugs, devices, and products when not purchased at a Pharmacy. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us for processing. The Drug Claim Form may be found at **asuris.myprime.com/v/ANH/COMMERCIAL/en/forms.html**. For more information, visit Our website or contact Customer Service.

Vasectomy and termination of pregnancy are subject to the minimum deductible amounts as described in the Internal Revenue Service (IRS) Minimum Deductibles Under HSA Plans provision.

SKILLED NURSING FACILITY

Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is necessary.

SPINAL MANIPULATIONS

Spinal manipulations are covered. Manipulations of extremities are covered in the Habilitation Services or Rehabilitation Services benefits.

SUBSTANCE USE DISORDER SERVICES

Substance Use Disorder Services for treatment of Substance Use Disorder Conditions are covered, including the following:

- acupuncture services; and
- Prescription Medications that are prescribed and dispensed through a substance use disorder treatment facility (such as methadone).

Definitions

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

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

Substance Use Disorder Conditions means substance-related disorders included in the most recent edition of the DSM 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, detoxification, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

For the 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.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

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

- 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.

"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" 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

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

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

For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Any organ or tissue which is procured outside the United States and any transplant procedure performed outside the United States are not covered.

Donor Organ Benefits

Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to:

- selection;
- removal of the organ;
- storage;
- transportation of the surgical harvesting team and the organ; and
- other such procurement costs.

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Some Providers may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share. To learn more about how to access virtual care services or the Providers that may offer lower-cost services, visit Our Website or contact Customer Service.

Store and Forward Services

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

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

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

Telehealth

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

Prescription Medications

This section explains Your benefits for Prescription Medications. Benefits will be paid in this Prescription Medications benefit, not any other provision, if a medication or supply is covered by both.

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. The Drug List may be viewed on Our website or by contacting Customer Service.

COVERED PRESCRIPTION MEDICATIONS

Covered Prescription Medications For Treatment of Illness or Injury

Prescription Medications benefits are available for the following:

- insulin and diabetic supplies (including, but not limited to, syringes, injection aids, lancets, blood glucose monitors, test strips for blood glucose monitors, urine test strips, prescriptive oral agents for controlling blood sugar levels and glucagon emergency kits), when obtained with a Prescription Order;
- certain continuous glucose monitors and insulin pumps (including their supplies), that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order; continuous glucose monitors and insulin pumps (including their supplies), are also covered in the Medical Benefits Section;
- 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 benefit 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;
- medications intended to treat opioid overdose that are on the Opioid Rescue Medication Value List found on Our website or by calling Customer Service;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- Self-Administrable Cancer Chemotherapy Medications;
- Self-Administrable Hemophilia Factor Drugs;
- 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;
- FDA-approved prescription hormone therapy (does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists); and
- growth hormones (if preauthorized).

Covered Preventive Medications

- certain preventive medications as recommended by the USPSTF including, but not limited to, aspirin, fluoride, iron, and medications for tobacco use cessation when obtained with a Prescription Order;
- pre-exposure prophylaxis (PrEP) medications for the prevention of HIV for people at a high risk of infection, as recommended by the USPSTF;
- post-exposure prophylaxis (PEP) medications for the prevention of HIV for people at a high risk of infection after an exposure, as recommended by the CDC;
    - You are not responsible for any Copay and/or Coinsurance for these post-exposure prophylaxis (PEP) medications for the prevention of HIV from a Participating Pharmacy; however, these medications are subject to minimum deductible amounts as described in the Internal Revenue Service (IRS) Minimum Deductibles Under HSA Plans provision.

- all FDA-approved prescription and over-the-counter contraception methods as described under the Reproductive Health Care Services benefit;
- 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, Copay 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 (except for immunizations for the purpose of travel, occupation, or residency in a foreign country), as specified above.

NOTE: FDA-approved over-the-counter contraceptive drugs, devices, and products are available from a Participating Pharmacy without a prescription and no cost-sharing. For more information on FDA-approved prescriptions and over-the-counter contraceptive products, visit Our website or contact Customer Service. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptives. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us for processing. The Drug Claim Form may be found at **asuris.myprime.com/v/ANH/COMMERCIAL/en/forms.html**.

Certain prescribed brand-name insulin drugs are made available at the Generic Medication payment level. If those designated insulin drugs are ineffective, other insulin drugs may be made available to You through Our Drug List exception process at the Generic Medication payment level. For more information, visit Our website or contact Customer Service.

Drugs prescribed for a use other than that stated in its FDA approved labelling, commonly referred to as off-label, will be covered as any other drug subject to the Drug List.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

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, please contact Us at 1-888-367-2109 or visit Our website.

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 **insurance.wa.gov**. If You have a concern about the Pharmacists or Pharmacies serving You, please contact the Washington State Department of Health at 1-360-236-4700.

Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. We notify In-Network Providers and Participating Pharmacies which Prescription Medications require preauthorization. Prescription Medications that require preauthorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require preauthorization will not be covered until they are preauthorized. For a list of medications that require preauthorization or if You have any questions, visit Our website or contact Customer Service.

Drug List Changes

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

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

Drug List Exception Process

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

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

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

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

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our website. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on Our website. You or Your requesting Provider will be notified of Our determination no later than 72 hours following receipt of the request. If You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Drug List medication, You or Your requesting Provider will be notified of Our determination no later than 24 hours following receipt of the request.

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

If preauthorization has not been approved for Your request, You have the right to appeal. Refer to the Appeal Process Section for more information on how to initiate an Appeal request.

The Drug List exception process may also be used to substitute a covered Prescription Medication for another drug on the Drug List if:

- You do not tolerate the covered Drug List medication; or
- Your Provider determines that the covered Drug List medication is not therapeutically efficacious for treating Your covered condition.

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 Schedule of Benefits 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.

Your Responsibility for Cost Differences of Chosen Medications

You will be responsible for the applicable Copay and/or Coinsurance for the Brand-Name Medication or Specialty Medication at the time of purchase. You will also be responsible for paying excess costs above Your applicable cost-share if either of the following occur:

- if You choose to fill a Prescription Order with a Brand-Name Medication and an equivalent Generic Medication is available, You will be responsible for paying the difference in cost; or
- if You choose to fill a Prescription Order with a Specialty Medication and a Specialty Biosimilar Medication is available, You will be responsible for paying the difference in cost.

The excess in cost does not apply toward any Deductible or any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication or the Specialty Medication must be dispensed, You will still be responsible for the excess in cost.

Pharmacy Network Information
A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on Our website or by contacting Customer Service. There are more than 1,200 Participating Pharmacies in Our Washington State network from which to choose.

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

Claims Submitted Electronically
Participating Pharmacies will submit claims electronically.

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 a copy of the form and the Prescription Medication receipt to Us. To find the Prescription Medication claim form, visit Our website or contact Customer Service.

We will reimburse You directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copay and/or Coinsurance required.

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

To buy Prescription Medications through the mail, send all of the following items to the Home Delivery Supplier at the address shown on the prescription home delivery form (which also includes refill instructions) available on Our website or from Your Group:

- a completed prescription home delivery form;
- any Deductible, Copay and/or Coinsurance; and
- the original Prescription Order.

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

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

Refills
You may obtain Prescription Medication refills once You have taken a minimum threshold amount of the previous medication fill(s). The minimum threshold amount is based on several factors, such as:

- a six-month look back period;

- the type of medication (for example, FDA-approved prescription contraceptives, controlled substances, Specialty Medications, or drugs in an adherence program); and
- state or federal laws.

This minimum threshold amount is generally once You have taken 75 percent of the previous medication fill(s), though certain exceptions may apply, such as:

- FDA-approved contraceptive drugs are covered for up to a 12-month supply from a Pharmacy, Home Delivery Supplier, or on-site at a Provider's office (if available);
- FDA-approved shelf-stable prescription hormone therapies are covered for up to a 12-month supply;
- topical ophthalmic prescriptions may be refilled only after You have taken 70 percent of the previous medication fill(s); and
- controlled substances.

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- receive maintenance medications for chronic conditions, You may qualify for prescription "refill synchronization" which allows refilling Prescription Medications on the same day of the month.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis.

Contact Customer Service for further information on prescription refills, refill synchronization, or to request an exception for an early refill.

Discounts or Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon may not apply toward Your Deductible or Out-of-Pocket Maximum. However, if there is a generic or therapeutic equivalent on Our Drug List, the reduction to Your cost-sharing will apply to Your Out-of-Pocket Maximum if the Prescription Medication was obtained through the Drug List exception process or step therapy (preauthorization) and You have met Your applicable plan Deductible. For more information, visit Our website or contact Customer Service.

LIMITATIONS

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

Prescription Medication Supply Limits

- 30-Day Supply Limit:
  - **Specialty Medications** – the largest allowable quantity for a Specialty Medication is a 30-day supply, unless the medication has an FDA-approved dosing regimen that exceeds 30 days and is packaged in a multi-month supply package. The Copay and/or Coinsurance, if applicable, is based on each 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 website or contact Customer Service. Specialty medications are not allowed through Home Delivery Suppliers.
- 90-Day Supply Limit:
  - **Participating Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Participating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copay and/or Coinsurance is based on each 30-day supply.
  - **Home Delivery Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.

- **Multiple-Month Supply** – the maximum number of days for a covered Prescription Medication that is packaged in a multiple-month supply and is purchased from a Participating Pharmacy is a 90-day supply (even if the manufacturer packaging includes a larger supply). The Copay and/or Coinsurance is based on the Prescription Order up to a 34-day supply within that multiple-month supply.

- **Maximum Quantity Limit**

  - For certain Prescription Medications, We establish maximum quantities other than those listed in the Schedule of Benefits. 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 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 identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.
  - For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Member's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
  - Any amount over the established maximum quantity is not covered, except if 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.

EXCLUSIONS

The following exclusions apply to this Prescription Medications Section and are not covered:

Biological Sera, Blood or Blood Plasma

Bulk Powders

Except as included on Our Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes

Prescription Medications used for Cosmetic purposes, including, but not limited to:

- removal, inhibition or stimulation of hair growth, except as related to a covered medical condition;
- anti-aging; or
- repair of sun-damaged skin.

Devices or Appliances

Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents

Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Digital Therapeutics

Except as included on Our Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications

Except for the following, foreign Prescription Medications are not covered:

- Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States; or
- Prescription Medications You purchase while residing outside the United States.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics
Except as provided in the Medical Benefits Section, general anesthetics are not covered.

Insulin Pumps and Pump Administration Supplies
Except as provided in the Durable Medical Equipment benefit, insulin pumps and supplies are not covered.

Medical Foods
Except as provided in the Medical Benefits Section, medical foods are not covered.

Medications that are Not Considered Self-Administrable
Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications
Except for the following, nonprescription medications that by law do not require a Prescription Order are not covered:

- medications included on Our Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

- over-the-counter medications;
- vitamins;
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any 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. Medications dispensed upon discharge should be processed by 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 FDA

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

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

Prescription Medications Not Dispensed by a Participating Pharmacy

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

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

Prescription Medications without Examination
Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS
The following definitions apply to this Prescription Medications Section:

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Participating Home Delivery Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Participating Home Delivery 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 website or by calling Customer Service. Medications are reviewed and selected for inclusion on 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.

Home Delivery Supplier means a home delivery Pharmacy with which We have contracted for home delivery services.

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. To find a Participating Pharmacy, visit Our website or contact Customer Service.

Participating Specialty Pharmacy means a Specialty Pharmacy with which We have a contract or a Specialty Pharmacy that participates in a network for which We have contracted to have access.

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

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

Preferred Brand-Name Medication and Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references as a Brand-Name Medication based on manufacturer and price.

Preferred Generic Medication and Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references 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.

Preferred Specialty Medications and Specialty Medications means medications that may be used to treat complex conditions, including, but not limited to:

- multiple sclerosis;
- rheumatoid arthritis;
- cancer;
- clotting factor for hemophilia or similar clotting disorders; and
- hepatitis C.

Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit Our website or contact Customer Service.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or
- are specifically included on Our Drug List.

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

Self-Administrable Prescription Medications, Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication 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). 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 Biosimilar Medication means an FDA-approved Prescription Medication that has a biological similarity to a Specialty Medication. The Specialty Biosimilar Medication is identical in function to the comparable Specialty Medication and may be more cost efficient. Similar to the FDA's requirements for a generic equivalent, a Specialty Biosimilar Medication must meet the same manufacturing and testing standards, and must be as safe and effective as the comparable Specialty Medication.

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

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

means a Specialty Medication not on the Drug List that is approved for coverage at the Specialty Medication benefit level.

Pediatric Vision Services

Vision Services are covered for Members under the age of 19. Coverage will be provided for a Member until the last day of the month in which the Member turns 19 years of age. Benefits will be paid in this Pediatric Vision Services benefit, not any other provision, if a service or supply is covered by both.

This pediatric vision coverage is provided by Us, in collaboration with Vision Service Plan (VSP), which coordinates the pediatric vision benefits and associated claims processing. VSP is a separate company that provides vision benefit services.

VISION EXAMINATION

Routine vision screening and comprehensive eye examination services are covered, including:

- refraction;
- dilation as professionally indicated;
- prescribing and ordering proper lenses;
- verifying the accuracy of the finished lenses; and
- progress or follow-up work as necessary.

VISION HARDWARE

Hardware including frames, contacts and lenses is covered, subject to any specified limits as explained in the following paragraphs:

Frames

One frame from a VSP Doctor is available per Calendar Year. However, for the VSP Doctor benefit level, frames are limited to the Otis & Piper Eyewear Collection.

Lenses

One pair of standard lenses is covered (in glass, plastic or polycarbonate) for one of the following:

- single vision;
- lined bifocal;
- lined trifocal;
- lenticular;
- photochromic lenses;
- elective contacts; or
- Necessary Contact Lenses.

Any of the following lens enhancements:

- scratch coating;
- UV (ultraviolet) protection; and
- tinting.

Contacts are available once per Calendar Year instead of all other lenses and frames. When You receive contact lenses, You will not be eligible for any lenses and/or frames again until the next Calendar Year. An annual supply of Necessary Contact Lenses, including disposable lenses for monthly, bi-weekly, or daily use, is covered if You have a specific condition for which contact lenses provide better visual correction.

If You choose non-Medically Necessary contact lenses instead of glasses, one of the following elective contact lens types may be chosen:

- standard (one pair annually);
- monthly (six-month supply);
- bi-weekly (three-month supply); or
- dailies (three-month supply).

CONTACT LENS EVALUATION AND FITTING EXAMINATION

One contact lens evaluation and fitting examination, including follow-up care, is also covered per Calendar Year.

LOW VISION BENEFIT

Low vision benefits for Members are covered, including optical devices (such as high power spectacles, magnifiers, telescopes), aids, annual comprehensive low vision examinations and follow-up visits if vision loss is sufficient enough to prevent reading and performing daily activities. Consult Your VSP Doctor for more details. Covered Services include professional services and ophthalmic materials, subject to any specified limits as explained in the following paragraphs:

Supplemental Examinations (Testing)

Supplemental examinations (complete low vision testing, analysis and diagnosis) which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or low vision aids where indicated.

Supplemental Aids

Low vision aids, including, but not limited to:

- optical;
- non-optical; and
- associated training.

DISCOUNTS FROM VSP DOCTORS

Discounts are available for the following services or supplies when received from a VSP Doctor:

- when You receive a complete pair of glasses, You are entitled to receive a 20 percent discount on non-covered materials;
- You are entitled to receive a 15 percent discount on contact lens examination services, beyond the covered vision examination; and
- VSP Doctors may request an additional vision examination at a discount within 12 months if necessary.

Discounts are applied to the VSP Doctor's usual and customary fees and are unlimited for 12 months on or following the date of the patient's last eye examination.

Discounts do not apply to:

- vision care benefits obtained from Out-of-Network Providers; or
- sundry items, including, but not limited to:
    - contact lens solutions;
    - cases;
    - cleaning products; or
    - repairs of spectacle lenses or frames.

THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.

PEDIATRIC VISION CLAIMS AND REIMBURSEMENT

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment.

Concerns about Claim Denial or Other Action

If You have a concern regarding a claim denial or other action in these Pediatric Vision Services benefits and wish to have it reviewed, You may Appeal. See the Appeal Process for a description of the process for Appeals. Additionally, if you have questions regarding reimbursement and subrogation recovery, see the Right of Reimbursement and Subrogation Recovery Section.

EXCLUSIONS
The following exclusions apply to this Pediatric Vision Services Section and are not covered:

Certain Contact Lens Expenses
- artistically-painted or non-prescription contact lenses;
- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

Corneal Refractive Therapy (CRT)
Reversals or revisions of surgical procedures which alter the refractive character of the eye, including orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Lens Enhancements
Except as provided in the Vision Hardware benefit, lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- Cosmetic lenses;
- laminated lenses;
- oversize lenses; or
- standard, premium and custom progressive multifocal lenses.

Medical or Surgical Treatment of the Eyes
Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Orthoptics or Vision Training
Except as provided in the Low Vision benefits, orthoptics, vision training and any associated supplemental testing are not covered.

Plano Lenses (Less Than a ± .50 Diopter Power)

Replacements
Replacement of any lost, stolen or broken lenses and/or frames.

Two Pair of Glasses in Lieu of Bifocals

DEFINITIONS
The following definitions apply to this Pediatric Vision Services Section:

Allowed Amount means:

- For VSP Doctors, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers, the amount determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services.

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 VSP.

Benefit Authorization means VSP has approved benefits for You.

Experimental Nature means a procedure or lens that is not used universally or accepted by the vision care profession.

Necessary Contact Lenses means contact lenses that are prescribed by Your VSP Doctor or Out-of-Network Provider for other than Cosmetic purposes. Benefit Authorization is not required for You to be eligible for Necessary Contact Lenses, however, certain benefit criteria, as defined by VSP, must be satisfied in order for contact lenses to be covered as Necessary Contact Lenses.

Out-of-Network Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care Provider who has not contracted with VSP to provide vision care services and/or vision care materials. For Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible, Copay and/or Coinsurance amount for Covered Services.

Vision Service means those vision-related services, supplies, treatment or accommodation provided for the diagnosis or correction of visual acuity. These services must be received from a Physician or optometrist practicing within the scope of their license.

VSP Doctor means a Physician or Practitioner (for example, an ophthalmologist or optometrist) who is duly licensed and who has contracted with VSP to provide vision care services and/or vision care materials to Members in accordance with the provisions of this coverage. The Provider Network for a VSP Doctor is identified on the Schedule of Benefits.

Pediatric Dental Services

Dental Services are covered for Members under the age of 19. Coverage will be provided for a Member until the last day of the month in which the Member turns 19 years of age. Benefits will be paid in this Pediatric Dental Services benefit, not any other provision, if a service or supply is covered by both. Preauthorization may be required for Dental Services to ensure they are Dentally Appropriate.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Preventive and diagnostic Dental Services are covered, subject to any specified limits as explained in the following:

- bitewing x-rays;
- cephalometric films;
- complete intra-oral mouth x-rays;
- diagnostic casts when Dentally Appropriate;
- limited oral evaluations to evaluate the Member for a specific dental problem or oral health complaint, dental emergency or referral for other treatment;
- visual oral assessments or screenings, not performed in conjunction with other clinical oral evaluation services;
- occlusal intraoral x-rays;
- oral hygiene instruction, if not billed on the same day as a cleaning;
- periapical x-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment;
- photographic images (oral and facial) when Dentally Appropriate;
- periodic and comprehensive oral examinations, limited to two per Calendar Year;
- problem focused oral examinations;
- panoramic mouth x-rays;
- sealants, when Dentally Appropriate;
- silver diamine fluoride (SDF), limited two per tooth per Calendar Year;
- topical fluoride application when Dentally Appropriate; and
- space maintainers (fixed unilateral or fixed bilateral) includes:

    - re-cementation of space maintainers;
    - removal of space maintainers; and
    - replacement space maintainers are covered when Dentally Appropriate.

- cleanings,* limited to two per Calendar Year

    *See the Dental4Health benefit below for the benefits that replace the coverage of cleanings listed here if You have a qualifying medical condition.

BASIC AND RESTORATIVE DENTAL SERVICES

Basic Dental Services are covered, subject to any specified limits as explained in the following:

- Complex oral surgery procedures including surgical extractions of teeth, impactions, alveoloplasty, frenulectomy, frenuloplasty, vestibuloplasty and residual root removal.
- Emergency treatment for pain relief.
- Endodontic services consisting of:

    - apexification for apical closures of anterior permanent teeth;
    - apicoectomy;
    - retrograde filling for anterior teeth;
    - debridement;
    - direct pulp capping;
    - pulpal therapy;
    - pulp vitality tests;
    - pulpotomy; and

- root canal treatment, including: treatment with resorbable material for primary maxillary incisor teeth D, E, F and G, if the entire root is present at treatment; treatment for permanent anterior, bicuspid, and molar teeth (excluding teeth 1, 16, 17 and 32); and retreatment for the removal of post, pin, old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material.

- Fillings consisting of composite and amalgam restorations:

  - five surfaces per tooth for permanent posterior teeth, except for upper molars;
  - six surfaces per tooth for teeth 1, 2, 3, 14, 15 and 16;
  - six surfaces per tooth for permanent anterior teeth;
  - restorations on the same tooth are limited to once in a two-year period; and
  - two occlusal restorations for the upper molars on teeth 1, 2, 3, 14, 15 and 16.

- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Member's health. Other services related to general anesthesia or intravenous sedation are covered as follows:

  - drugs and/or medications only when used with parenteral conscious sedation, deep sedation, or general anesthesia;
  - inhalation of nitrous oxide, once per day; and
  - local anesthesia and regional blocks, including office-based oral or parenteral conscious sedation, deep sedation or general anesthesia.

- Periodontal services consisting of:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery);
  - debridement;
  - gingivectomy and gingivoplasty, once per quadrant in a three-year period;
  - scaling and root planing, once per quadrant in a two-year period; and
  - periodontal maintenance,* once per quadrant in a Calendar Year.

  *See the Dental4Health benefit below for the benefits that replace the coverage of cleanings listed here if You have a qualifying medical condition

- Uncomplicated oral surgery procedures including brush biopsy, removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

Major Dental Services are covered, subject to any specified limits as explain in the following:

- Adjustment and repair of dentures and bridges:

  - adjustments within 90 days of delivery (placement) will not be separately reimbursed;
  - the cost of repairs cannot exceed the cost of a replacement denture or a partial denture; and
  - additional repairs on a case-by-case basis and when prior authorized.

- Behavior management.
- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than five years after placement.
- Crowns and core build-ups, limited to the following:

  - an indirect crown, for permanent anterior teeth, one per tooth in a five-year period;
  - cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;
  - core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;
  - recementations of permanent indirect crowns;

  - stainless steel crowns for primary anterior and posterior teeth, once in a three-year period; and
  - stainless steel crowns for permanent posterior teeth (excluding teeth 1, 16, 17 and 32), once in a three-year period.

- Dental implant crown and abutment related procedures, limited to one per tooth in a five-year period.
- Dentures, full and partial, including:

  - adjustment and repair of dentures and bridges, limited to one per arch in a 12-month period;
  - denture rebase, limited to one per arch in a three-year period, if performed at least six months from the seating date;
  - denture relines, limited to one per arch in a three-year period if performed at least six months from the seating date;
  - one complete upper and lower denture, and one replacement denture per Lifetime after at least five years from the seat date; and
  - one resin-based partial denture, replaced once within a three-year period.

- Endosteal implants, limited to one per tooth per Lifetime.
- Home visits, including extended care facility calls, limited to two calls per facility per Provider.
- Medically Necessary orthodontic services for Members with malocclusions associated with:

  - cleft lip and palate, cleft palate and cleft lip with alveolar process involvement; and
  - craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, arthrogryposis or Marfan syndrome.

- Occlusal guards.
- Post-surgical complications.
- Repair of crowns, limited to one per tooth.
- Repair of implant supported prosthesis or abutment, limited to one per tooth.

DENTAL4HEALTH®

Enrollment in Our Dental4Health (D4H) Program, which provides enhanced preventive and periodontal services, outreach, education, and specialized care programs, is available to Members with eligible medical conditions. For Members enrolled in D4H, these expanded benefits replace the like services listed in Preventive and Diagnostic Dental Services and Basic and Restorative Dental Services benefits.

The following coverage is provided for each Member who is enrolled in D4H and who has been diagnosed with diabetes, coronary artery disease, stroke, chronic obstructive pulmonary disease, end stage renal disease, metabolic syndrome, or who is pregnant:

- Cleanings (standard or periodontal maintenance cleanings), limited to four combined visits per Member per Calendar Year.
- Periodontal scaling and root planing, limited to once per Member per quadrant in a two-year period.
- Periodontal debridement, limited to once per Member in a two-year period.

The following coverage is provided for each Member who is enrolled in D4H and who has been diagnosed with head and neck cancer, oral cancer, or Sjögren's syndrome:

- Cleanings (standard or periodontal maintenance cleanings), limited to four combined visits per Member per Calendar Year.
- Topical fluoride application for all ages, limited to once every three months per Member per Calendar Year.
- Periodontal debridement, limited to once per Member in a two-year period.
- Oral examinations, limited to four per Member per Calendar Year.

D4H benefits are available at the enhanced coinsurance amount after the medical deductible is met.

PEDIATRIC DENTAL CLAIMS AND REIMBURSEMENT

In-Network Dentist Claims and Reimbursement

You must present Your identification card to an In-Network Dentist and furnish any additional information requested. The In-Network Dentist will submit the necessary forms and information to Us for processing Your claim.

We will pay an In-Network Dentist directly for Covered Services. These In-Network Dentists may require You to pay any Deductible, Copay and/or Coinsurance at the time You receive care or treatment. In-Network Dentists have agreed not to bill You for balances beyond any Deductible, Copay and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

EXCLUSIONS

The following exclusions apply to this Pediatric Dental Services Section and are not covered:

Aesthetic Dental Procedures

Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth.

Antimicrobial Agents

Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Collection of Cultures and Specimens

Connector Bar or Stress Breaker

A device attached to a prosthesis or coping which serves to stabilize and anchor prosthesis.

Cosmetic/Reconstructive Services and Supplies

Except for the following, Cosmetic and/or reconstructive services and supplies are not covered:

- Dentally Appropriate services and supplies to treat a congenital anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

"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 generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Desensitizing

Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Duplicate X-Rays

Fractures of the Mandible (Jaw)

Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Implants

Services and supplies provided in connection with implants, whether or not the implant itself is covered including:

- endodontic endosseous implants;
- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lifts;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and

- unspecified implant procedures.

Indirect Pulp Capping as a Separate Charge

Interim Partial or Complete Dentures

Medications and Supplies
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies are not covered, except as explicitly provided in the Pediatric Dental Services Section.

Non-Emergency Services While Outside of the United States

Occlusal Treatment
Services and supplies provided in connection with dental occlusion, including occlusal analysis and adjustments are not covered, except as explicitly provided in the Pediatric Dental Services Section.

Oral Surgery to Treat a Fractured Jaw and Orthognathic Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Orthodontic Dental Services
Services and supplies provided in connection with orthodontics are not covered, except as explicitly provided in the Pediatric Dental Services Section, including:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures; and
- procedures for tooth movement, regardless of purpose.

Precision Attachments
Device to stabilize or retain a prosthesis when seated in mouth.

Prosthesis
Services and supplies provided in connection with dental prosthesis, including the following:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting
Interim or temporary stabilization of loose/mobile teeth.

Replacements
Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken are not covered, except as explicitly provided in the Pediatric Dental Services Section.

Separate Charges
Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including:

- any supplies;
- local anesthesia; and
- sterilization.

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures:

- exfoliative cytology sample collection;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; and
- surgical procedures for isolation of a tooth with rubber dam.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided in connection with temporomandibular joint (TMJ) disorder, except as explicitly provided in the Medical Benefits Section.

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including implantation from one site to another and splinting and/or stabilization.

Tobacco or Nutritional Counseling for the Control and Prevention of Oral Disease
Except for services provided without a separate charge in connection with Covered Services that train or educate a Member, tobacco or nutritional counseling for the control and prevention of oral disease are not covered.

Veneers
Thin laminated restoration that covers the facial surface and/or the incisal edge of a tooth, and/or may extend between the adjoining surfaces of adjacent teeth.

DEFINITIONS
The following definitions apply to this Pediatric Dental Services Section:

Allowed Amount means:

- For In-Network Dentists, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Dentists, the amount We have determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by Us or as otherwise required by law.

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

Dentally Appropriate means a Dental Service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and is all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Member's condition; and
- not primarily for the convenience of the Member, Member's Family or Provider.

A dental service may be dentally appropriate yet not be a covered service in this Booklet.

Dentist means an individual who is duly licensed to practice dentistry in all of its branches (including a doctor of medical dentistry, doctor of dental surgery or a denturist) or to practice as a dental hygienist who is permitted by their respective state licensing board, to independently bill third parties.

In-Network Dentist means a contracted Dentist in Your Provider network who provides services and supplies to Members in accordance with the provisions of this coverage. The Provider network for an In-Network Dentist is identified on the Schedule of Benefits.

Out-of-Network Dentist means a Dentist who is not in Your Provider network.

General Exclusions

The following are the general exclusions from coverage, other exclusions may apply as described elsewhere in this Booklet.

SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

- 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;
- a preventive service as specified in the Preventive Care and Immunizations benefit and/or in the Prescription Medications Section.

Activity Therapy

The following activity therapy services are not covered:

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

Adventure, Outdoor, or Wilderness Interventions and Camps

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

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

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

Assisted Reproductive Technologies

Except as provided in the Other Professional Services benefit, assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to:

- donor semen or donor eggs;
- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- embryo transfer;

- other artificial means of conception, such as ovum transplants, gamete intrafallopian transfer, or zygote intrafallopian transfer; or
- any associated surgery, medications, testing or supplies.

Certain Therapy, Counseling and Training
Except as provided in the Employee Assistance Program (EAP), the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling; and
- 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
This exclusion does not apply to services that are prescribed as Medically Necessary for Gender Affirming Treatment, to the extent such services are permitted under applicable law and are in accordance with accepted standards of care.

Counseling in the Absence of Illness
Except as required by law, counseling in the absence of Illness is not covered.

Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

Dental Services
Except as provided in the Pediatric Dental Services or Temporomandibular Joint (TMJ) Disorders benefits, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

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

Family Counseling
Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

Fees, Taxes, Interest
Except as required by law or as outlined in the Durable Medical Equipment benefit, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- 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.

Government Programs
Except as required by law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this plan) by any federal, state or government program are not covered.

Additionally, except as listed below, government facilities or government facilities outside the Service Area are not covered:

- as required by law for emergency services.

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

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- Mental Health Conditions;
- Substance Use Disorders; or
- for anesthesia purposes.

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

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

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except as provided in the Other Professional Services benefit, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility drugs; and
- other medications associated with fertility treatment.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by 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
Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for 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
Except as provided in the Nutritional Counseling benefit, as required as part of the USPSTF, HRSA, or CDC requirements, or as required by law, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including treatment of complications, revisions and reversals); or
- programs.

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

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

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

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

Over-the-Counter Contraceptives
Over-the-counter contraceptive supplies unless approved by the FDA are not covered, except as covered under the Reproductive Health Care Services benefit, Prescription Medications Section or as required by law.

Personal Items
Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;

- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

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

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Routine Hearing Examinations
“Routine hearing examination” means a hearing examination or screening, not otherwise Medically Necessary, performed when there is no underlying hearing loss or other specific symptoms to address.

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

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

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

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

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:

  - school;
  - a camp;
  - a sports team;
  - the military; or
  - any other institution.

- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:

  - employment or return to work;
  - marriage;
  - insurance;
  - occupational injury benefits;
  - licensure; or
  - certification.

- travel, immigration or emigration.

Sexual Dysfunction
Except as provided in the Mental Health Services benefit, treatment, services and supplies are not covered for or in connection with sexual dysfunction regardless of cause.

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

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

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

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

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

Varicose Vein Treatment
Except as provided in the Other Professional Services benefit, treatment of varicose veins is not covered.

Vision Care
Except as provided in the Pediatric Vision Services Section, vision care services are not covered, including, but not limited to:

- routine eye examinations;

- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

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

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

If an Illness or Injury could be considered work-related, a Member will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

Contract and Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, We decide whether to pay You, the Provider or You and the Provider jointly, subject to any legal requirements.

In-Network Provider Claims and Reimbursement

You must present Your identification card to an In-Network Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to Us for processing Your claim.

We will pay an In-Network Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copay and/or Coinsurance at the time You receive care or treatment. In-Network Providers have agreed not to bill You for balances beyond any Deductible, Copay and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

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. 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;
- the patient's name;
- Your identification number; and
- the group number.

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.

Our standard policy is to make payment for Out-of-Network Provider claims directly to the Provider or, with submission of sufficient documentation that the Member has already "paid in full," solely to the Member.

Out-of-Network Providers may not agree to accept the Allowed Amount as payment for Covered Services. You may be responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copay 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.

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

Timely Filing of Claims

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

Claim Determinations
Within 30 days of 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 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 of 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.

CONTINUITY OF CARE
You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if one of the following situations apply:

- Your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud); or
- Your Group's Contract with Us is terminated for reasons other than fraud, and your Group's new health plan does not include Your In-Network Provider in its network.

To qualify for continued coverage, You must be:

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

We will notify You of Your right to receive continued care from the Provider or You may contact Us with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Booklet and provided on the same terms and conditions as any other In-Network Provider. Your Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copay and/or Coinsurance. Contact Customer Service for further information and guidance.

PRIOR APPROVAL OF OUT-OF-NETWORK PROVIDERS
If a Covered Service is Medically Necessary, but there is not reasonable access to an In-Network Provider, You may be able to receive coverage for such services from an Out-of-Network Provider. To receive coverage, You or the Provider must request prior approval before You receive services. When prior approved, Covered Services received from the Out-of-Network Provider will be reimbursed at the In-Network benefit level.

If the Out-of-Network Provider does not have a contract with Us or the local Blue Cross and/or Blue Shield Licensee, You may be 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 any Deductible, Copay and/or Coinsurance. Any amounts You pay for non-Covered Services or in excess of the Allowed Amount do not apply toward the Deductible or Out-of-Pocket Maximum. Contact Customer Service for further information and guidance.

NOTE: It is Your responsibility to obtain prior approval for any such Out-of-Network Provider services. If You do not obtain prior approval, services will not be covered. The Out-of-Network Provider can bill You directly and You will have to pay the total cost of the services. These costs do not apply toward the Deductible or Out-of-Pocket Maximum.

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 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 by 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 Right of Reimbursement and Subrogation Recovery provision 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 Illness or Injury 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 Illness or Injury 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 Contract 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 Contract 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.

Coordination of Benefits with a High Deductible Health Plan
Laws strictly limit the types of other coverages that a health savings account (HSA) participant may carry in addition to their qualified high deductible health plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. We will coordinate benefits according to this Coordination of Benefits provision, regardless of whether other coverage is permissible per HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

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.

- 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 the Provider 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.

Facility of Payment

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

Right of Recovery

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

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

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

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

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

Appeal and Grievance Process

This provision describes the process for submitting an appeal or Grievance. You may submit an appeal, as detailed below, if You or Your Representative want a review of a claim denial or other dispute. There is one level of Internal Appeal, in addition to an External Review with an Independent Review Organization. Situations that require a faster decision may also qualify for an Expedited Appeal. For complaints not involving an appeal, You may submit a Grievance as detailed under the Grievance Process provision.

For pediatric vision benefits, We have delegated the appeal process to VSP, though We retain ultimate responsibility over the appeal process. The terms “We,” “Us” and “Our” for the purpose of pediatric vision appeals refer to VSP. If You believe a policy, action, or decision is incorrect, contact the VSP Customer Service department.

NOTE: Records or other materials that include others' medical or health records and other personal health information should not be submitted for appeals or Grievances.

WHAT YOU MAY APPEAL

You may appeal disputes regarding:

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

Appeals must be pursued within 180 days of Your receipt of Our determination (Internal Appeals must be pursued 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 pursue an appeal. You have the right to review copies of all documents, records and information relevant to any claim that is the subject of the appeal, upon request and free of charge.

VSP appeals can be initiated through either a written or verbal request using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Create an account or complete the form available at **vsp.com**
Phone	Call 1-844-299-3041 for VSP's Customer Service department (TTY: 711) Customer Service hours: Monday through Saturday, 6 a.m. to 5 p.m., Pacific time
Mail	Attn: Appeals Department Vision Service Plan P.O. Box 2350 Rancho Cordova, CA 95741

For all other benefits in this coverage, appeals can be initiated through either a written or verbal request using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Sign into your account at **asuris.com** Navigate to Appeals and appeal online
Email	MemberAppeals@**asuris.com**
Fax	1-888-496-1542
Phone	Call the Customer Service phone number on Your identification card
Mail	Attn: Member Appeals Asuris Northwest Health P.O. Box 1106 Lewiston, ID 83501-1106

When We receive an appeal request, We will send a written acknowledgement within 72 hours of receiving the request. 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 the disputed inpatient care benefits or any benefit for which a continuous course of treatment is Medically Necessary, pending the outcome of Our review. If We deny Your 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.

APPEAL DETERMINATION TIMING

Type of Appeal	When to Expect a Response
Internal Appeal involving a Post-Service investigational issue	In writing, within 20 working days of Our receipt of the appeal.
Internal Appeal involving all other issues	In writing, within 14 days of Our receipt of the appeal.
Internal Expedited Appeal	Verbal notice as soon as possible, but no later than 72 hours of receipt of the appeal, followed by written notice within 72 hours of the date of the decision.
Voluntary External Review by an Independent Review Organization (IRO)	In writing, within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request.
Voluntary Expedited Review by an Independent Review Organization (IRO)	Verbal notice as soon as possible, but no later than 72 hours of the IRO's receipt of the necessary information, followed by written notice within 48 hours of the verbal notice.

INTERNAL APPEALS

Internal Appeals are reviewed by an employee or employees who were not involved in the adverse decision. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony. In appeals that require medical judgment, the review is completed by Our

staff of health care professionals. 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 REVIEW – IRO

A voluntary review by an Independent Review Organization (IRO) is available if the request 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 Review, 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 five business days to submit additional written information directly to the IRO for consideration. Choosing the voluntary External Review 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 Review by an IRO is optional and You should know that other forums may be utilized as the final level of review to resolve a dispute. This includes, but is not limited to, civil action under Section 502(a) of ERISA, where applicable.

EXPEDITED APPEALS

An Expedited Appeal is available within 180 days of Your receipt of Our determination 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. When concurrent expedited reviews are requested, the requisite timelines will be applied concurrently, not consecutively.

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 include an appropriate clinical peer in the same or similar specialty as would typically manage the case. You or Your Representative will be given the opportunity (within the constraints of the Expedited Appeals time frame) to provide written materials, including written testimony on Your behalf.

Voluntary Expedited Review – 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 Review by an IRO. The criteria for a voluntary Expedited Review by an IRO are the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Review at the same time You request an Expedited Appeal from Us.

We coordinate voluntary Expedited Reviews, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Expedited Review documentation, which is available to You or Your Provider upon request. Choosing the voluntary Expedited Review 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 Review 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.

GRIEVANCE PROCESS

If You or Your Representative has a complaint not involving an Adverse Benefit Determination and wish 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:

Method of Request	Contact Information
Phone	Call Customer Service at 1-888-367-2109
Mail	P.O. Box 1106 Lewiston, ID 83501

A Grievance may be registered when You or Your Representative express dissatisfaction with any matter not involving an Adverse Benefit Determination, including, but not limited to Our customer service, 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 on a quarterly basis for improvements. If You would like a written response or acknowledgement of Your Grievance, request one at the time of submission.

ASSISTANCE

For assistance with internal claims, 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: **insurance.wa.gov**

DEFINITIONS

The following definitions apply to this Appeal and Grievance Process section:

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 an enrollee'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.

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.

External Review 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 that acts as the decision-maker for voluntary External Appeals and voluntary External Expedited Appeals and that 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 or the Grievance. 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. No authorization is required from the parent(s) or legal guardian of an enrolled dependent child who is less than 13 years old. For Expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative 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.

Eligibility and Enrollment

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 open enrollment period. It describes when coverage under the Contract begins for You and/or Your eligible dependents. Payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of initially becoming eligible for coverage per 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.

If You and/or Your eligible dependents do not enroll for coverage under the Contract when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual open enrollment period to enroll, except as described in the Special Enrollment provision below.

Employees

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

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, stepchild, 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; or
  - 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) child who is age 26 or over and incapable of self-support because of developmental or physical disability that began before the child's 26th birthday. You must 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:

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

  Our affidavit of dependent eligibility form is available by visiting Our website or by calling Customer Service. We may request an annual update on the child's disability 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 open 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.

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 (or, if You are a child, You and Your parent who is not enrolled on this same plan) are eligible to apply for coverage under the Contract within 60 days from the date of the qualifying event:

- Loss of coverage due to a loss of employer sponsored insurance coverage (for any reason) other than Your fraud or misrepresentation of material fact.
- Loss of individual or group coverage of a person through whom You were covered.
- Loss of eligibility for Medicaid or a public program providing health benefits.
- Loss of coverage as the result of dissolution of marriage or termination of a domestic partnership.
- A permanent change in residence, work, or living situation, whether or not Your choice, where the health plan under which You were covered does not provide coverage in Your new service area.
- Loss of coverage because the plan is no longer offered to a class of similarly situated individuals that includes You.
- Loss of individual or group health exchange coverage due to an error by the exchange, the issuer, or the United States Department of Health and Human Services.

For the above qualifying events, if enrollment is requested as specified, coverage will be effective no later than the first of the next month following receipt of Your application.

If You are already enrolled or if You declined coverage when first eligible and You subsequently acquire a child by birth, adoption, or Placement for Adoption, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 60 days from the date of the qualifying event. If enrollment is requested as specified, coverage will be effective from, respectively, the date of birth, adoption, or placement.

If You are already enrolled or if You declined coverage when first eligible and You subsequently marry or begin a domestic partnership, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 60 days from the date of the qualifying event. If enrollment is requested as specified, coverage will be effective as of the first of the month following the marriage or commencement of the domestic partnership.

If You are already enrolled or if You declined coverage when first eligible and 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 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).
- The Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective for an eligible dependent to have coverage under the Contract.

If enrollment is requested as specified, coverage will be effective as of the first of the month following the qualifying event.

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:

- You and/or Your eligible dependent loses coverage under another group or individual health benefit plan due to one of the following:
    - The other plan is federal COBRA or any state continuation and is exhausted.
    - The other plan is not federal COBRA or any state continuation and either:
        - An employer's contributions to that other plan are terminated.
        - Eligibility for that other plan is lost, for instance due to divorce, legal separation, termination of domestic partnership, death, termination of employment, or reduction in hours.

If You are already enrolled or if You declined coverage when first eligible and subsequently You and/or Your eligible dependent exhausts any lifetime maximum on total benefits under another group or individual health benefit plan, 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 the first claim is denied under that other health benefit plan on the basis of lifetime maximum exhaustion.

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

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 losing group coverage as a result of any of the following qualifying events:

- The death of an employee of the group.
- The termination of employment (other than for gross misconduct) or reduction in working hours of an employee of the group.
- The divorce or legal separation of an employee of the group.
- The Medicare entitlement of an employee of the group.
- Loss of status as an eligible child under the group coverage.
- A Chapter 11 bankruptcy filing by the employer sponsoring the group.

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the first of the next month following receipt of Your application (if Your application is received by the fifteenth day of the month) or on the first day of the second following month (if Your application is received after the fifteenth day of the month).

ANNUAL OPEN ENROLLMENT PERIOD

The annual open 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 provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

DEFINITIONS

The following definitions apply to this Eligibility and Enrollment Section:

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.

When 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 Continuation of Coverage, Non-COBRA Continuation of Coverage, or the Other Continuation Options Sections.

Termination of Your Employment or You are 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 premium contributions, coverage will end for You and all Enrolled Dependents.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Enrolled Dependents on the last day of the month in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the COBRA Continuation of Coverage or the Non-COBRA Continuation of Coverage Sections.

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.
- Eligibility ends on the date in which an enrolled child is removed from placement due to disruption of placement before legal adoption.

OTHER CAUSES OF TERMINATION

Members terminated for the following reason may be able to continue coverage under the Contract according to the COBRA Continuation of Coverage or the Non-COBRA Continuation of Coverage Sections.

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.

FAMILY AND MEDICAL LEAVE

If Your Group grants You a leave of absence under an applicable state or federal family and medical leave law the following rules will apply. The federal Family and Medical Leave Act is generally applicable to private employers of 50 or more employees and public employers of any size. But state law may be applicable more broadly. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the applicable law:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the leave for a period of up to 12 weeks, or as required by law, 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 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 leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the leave. In order to reenroll after You return from a 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 leave and You will not have to re-serve any probationary period under the Contract.

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 according to this provision. Entitlement to leave does not constitute a qualifying event for COBRA continuation. However, a person who does not return to active employment following leave may be entitled to COBRA continuation

coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the leave.

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

MILITARY LEAVE OF ABSENCE

If You are covered under this plan and are called to active duty or join any branch of the United States armed forces, and Your military duty would result in a loss of coverage under this plan, You are eligible for continued coverage under this plan for up to 24 months or the duration of Your military leave, whichever is shorter, under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Continuation of Coverage

This continuation of coverage is in lieu of and not in addition to any other continuation of coverage provisions. Your dependents do not have an independent right to elect USERRA coverage.

Premium Contributions

To maintain coverage during Your leave, You must pay premiums to the employer Group. If Your leave is less than 30 days, Your premium contribution rate will be the same as for active employees. If Your leave is 30 days or longer, Your premium contribution will not exceed 102% of the cost of coverage for active employees.

Provisions and Limitations

When Your coverage under this plan is reinstated, all provisions and limitations of this plan will apply as if You had not taken Your military leave and Your coverage had been continuous. You will not have to serve any group eligibility waiting period. However, this waiver of limitations does not provide coverage for any illness or injury caused or aggravated by Your military service, as determined by the Veterans Administration.

For complete information regarding Your rights under USERRA, contact the employer Group.

LEAVE OF ABSENCE

If You are granted a temporary non-family and medical 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 non-family and medical 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 a family and medical leave under applicable law, You remain eligible under the Contract only for a period equivalent to legally required leave and may not also continue coverage with a non-family and medical 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 open enrollment period.

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 or the marriage is annulled;
- You and Your 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 per 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

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 two percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Enrolled Dependent's rights with COBRA, You or Your Enrolled Dependents must inform the Group in writing within 60 days of:

- Your divorce or annulment, termination of 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 per Social Security 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 per Social Security, 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.

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 makes determinations for eligibility of non-COBRA continuation of coverage and 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;
- three 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.

Other Continuation Options

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

Availability of Other Coverage

When eligibility under the Contract terminates at the end of or in lieu of any available COBRA continuation coverage period, or otherwise upon termination of this coverage, an individual insurance policy, conversion plan, or Medicare supplement plan may be available through Us. The policy or plan will have equal or lesser benefits than this coverage.

You may be able to enroll in one of Our conversion plans, if offered in Your service area, when eligibility under the Contract terminates and You are under age 65 and ineligible for Medicare or other group coverage. We must receive the conversion plan application and first month's premium within 31 days of termination of coverage or the date You receive notice of Contract termination (whichever is later). For more information, or to request an application, contact Customer Service.

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 and Enrolled Dependents may continue coverage under the Contract 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. 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 and legal notices 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 by 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. However, 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 per 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, 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 their rights per ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, the employee 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. According to 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, the employee may file suit in a state or federal court. An employee may also do so if they disagree 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 their 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, they should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or their rights per ERISA, or if they need 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 this Booklet. 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 to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment,

transfer or delegation of benefits will be considered null and void and will not be binding on 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 mailed to Our Customer Service address. However, notice to Us will not be considered to have been given to and received by Us until physically received by Us.

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 provided by applicable law.

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 for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

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 website 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. A specific authorization will be obtained from You in order for Us to receive information related to these health conditions.

TAX TREATMENT

We do not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements or rewards through a value-added program.

WE ARE NOT RESPONSIBLE FOR HSA FINANCIAL OR TAX ARRANGEMENTS

You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. We do not assume any liability associated with Your contribution to an HSA during any period that this high deductible health plan does not qualify for use with an HSA. An HSA is a tax-exempt account established per Section 223(d) of the Internal Revenue Code exclusively for paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health plan (and not be enrolled in other coverage). Note that the tax references contained in this Booklet relate to federal income tax only. The tax treatment of HSA contributions and distributions per Your state's income tax laws may differ from the federal tax treatment and differs from state to state.

We do not provide tax advice and assume no responsibility for reimbursement from the custodial financial institution for any HSA with which this high deductible health plan is used. Consult with Your financial or tax advisor for tax advice or for more information about Your eligibility for an HSA.

WHEN BENEFITS ARE AVAILABLE

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

- the person is eligible to be covered according to the eligibility provisions in 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.

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

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers, the amount We have determined to be reasonable charges or have negotiated for Covered Services. The Allowed Amount may be based upon billed charges for some services, 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 Customer Service.

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

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us. We will create and furnish Booklets to the Group identifying the general provisions and Schedule of Benefits, for distribution to each Enrolled Employee.

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.

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

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

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

Custodial Care means care 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 preventing self-harm.

Dental Service means services or supplies (including medications) that are 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) and are Dentally Appropriate.

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.

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

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

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 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 any Enrolled Dependents.

Gender Affirming Treatment means Medically Necessary Covered Services (to the extent such services are permitted under applicable law) provided by a Provider and prescribed in accordance with generally accepted standards of care, to treat any condition related to an individual's gender expression or identity. For more information, visit Our website at **asuris.com/member/lgbtq-support**.

Ground Ambulance Services Organization means a public or private organization licensed by the department of health to provide ground ambulance services in the state of Washington. Ground Ambulance Service Organizations provide Covered Services at the scene of a medical emergency or while transporting a patient to a health care facility equipped to provide treatment, including between health care facilities when Medically Necessary.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following:

- disease;
- Illness or Injury;
- genetic or congenital anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or
- to maintain or restore functional ability.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital per 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;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Illness does not include any state of mental health or mental disorder (which is otherwise defined).

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- 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.

In-Network Provider means a contracted Provider with Us in Your Provider network who provides services and supplies to Members in accordance with the provisions of this coverage. Your Provider network is identified on the Schedule of Benefits and may include Our Affiliates.

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. "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;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- 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.

Medical Necessity determinations are made by health professionals applying their training and experience, and using applicable medical policies developed through periodic review of generally accepted standards of medical practice.

Member means an Enrolled Employee or an Enrolled Dependent.

Nonparticipating Facility means an Out-of-Network facility that does not have any effective participating contract with Us, or with one of Our Affiliates.

Out-of-Network Provider means a Provider that is not In-Network.

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

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

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

Provider means:

- a Hospital;
- a Skilled Nursing Facility;
- an Ambulatory Surgical Center;
- a Physician;
- a Practitioner; or
- other individual or organization which is duly licensed to provide medical or surgical services.

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;
- an Ambulatory Surgical Center;
- an urgent care center;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a 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. Your Service Area is identified on the Schedule of Benefits.

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

Appendix: Value-Added Services

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

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

An EAP is short-term, confidential counseling with no out-of-pocket expense. This EAP is available to the following "clients":

- the Enrolled Employee;
- the Enrolled Employee's legal dependents (whether or not they are enrolled in this coverage or living in the Enrolled Employee's home); and
- anyone living in the Enrolled Employee's home (whether or not they are enrolled in this coverage or related to the Enrolled Employee).

You will receive a welcome packet that includes contact information and details of the following services which are provided as part of this EAP:

- **24-Hour Crisis Counseling**
  The EAP hotline number is answered by professional counselors 24 hours a day, 7 days a week.

- **Short-Term Counseling**
  An "incident" means a separate event or events occurring in the client's life. Four counseling sessions will be covered per incident. Each client affected by an incident will be eligible for a total of four counseling sessions. If two or more clients are seen together in a joint session, the session is counted as one visit for each attending client.

- **Referral**
  If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor may refer the client to extended care, community resources or another Provider as best suited to address the issue and referred services will not be part of this EAP. Services not included in this EAP will be subject to the benefits in this Booklet.

- **Follow-up**
  When necessary and appropriate, the counselor may follow up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if this EAP service can be of further assistance.

JOINT, SPINE, AND MUSCLE PROGRAM

The Joint, Spine and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. In addition, based upon Your specific health condition, You may have access to a customized care plan including guided exercise therapy, one-on-one video coaching with a care team, curated health education, and behavior change support. For those who do not have a way to participate in the digital program please visit Our website or contact Customer Service. You may be eligible for the following at no cost to You:

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

KIDNEY HEALTH MANAGEMENT

If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD). The program defers progression of CKD, reduces the cost of care by avoiding adverse events such as emergency room visits, hospitalizations and post-acute care.

NURSE ADVICE

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

PREGNANCY PROGRAM

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

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

WELL-BEING PROGRAM

The Well-Being Program offers a range of tools, information and support for a healthy lifestyle. **This program is separate from the Employee Wellness Reward.** It may include the following:

- earning up to a total of $25 in gift cards for completion of well-being activities such as an online health risk assessment (for Members who are not eligible for the Employee Wellness Reward);
- earning up to a total of $50 in gift cards for completion of well-being activities such as health screening(s) and/or wellness examination(s) (for Members who are also eligible for the Employee Wellness Reward);
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

For more information call Us at 1-888-367-2109

asuris.com

[*This plan arranged by:*

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