BOOKLET FOR:

KING COUNTY

Group Number: 10017241

ATU KingCare Select Eastside Health Network

Medical Benefits

Know your rights under the Balance Billing Protection Act

Beginning January 1, 2020, Washington state law protects you from 'surprise billing' or 'balance billing' if you receive emergency care or are treated at an in-network hospital or outpatient surgical facility

What is 'surprise billing' or 'balance billing' and when does it happen?

Under your health plan, you're responsible for certain cost-sharing amounts. This includes copayments, coinsurance and deductibles. You may have additional costs or be responsible for the entire bill if you see a provider or go to a facility that is not in your plan's provider network.

Some providers and facilities have not signed a contract with your insurer. They are called 'out-of-network' providers or facilities. They can bill you the difference between what your insurer pays and the amount the provider or facility bills. This is called 'surprise billing' or 'balance billing.'

Insurers are required to tell you, via their websites or on request, which providers, hospitals and facilities are in their networks. And hospitals, surgical facilities and providers must tell you which provider networks they participate in on their website or on request.

When you CANNOT be balance billed:

Emergency Services
The most you can be billed for emergency services is your plan's in-network cost-sharing amount even if you receive services at an out-of-network hospital in Washington, Oregon or Idaho or from an out-of-network provider that works at the hospital. The provider and facility cannot balance bill you for emergency services.

Certain services at an In-Network Hospital or Outpatient Surgical Facility
When you receive surgery, anesthesia, pathology, radiology, laboratory, or hospitalist services from an out-of-network provider while you are at an in-network hospital or outpatient surgical facility, the most you can be billed is your in-network cost-sharing amount. These providers cannot balance bill you.

In situations when balance billing is not allowed, the following protections also apply:

- Your insurer will pay out-of-network providers and facilities directly. You are only responsible for paying your in-network cost-sharing.
- Your insurer must:
  - Base your cost-sharing responsibility on what it would pay an in-network provider or facility in your area and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or certain out-of-network services (described above) toward your deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 30 business days.
- A provider, hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill.

This law does not apply to all health plans. If you get your health insurance from your employer, the law might not protect you. Be sure to check your plan documents or contact your insurer for more information.

If you believe you've been wrongly billed, file a complaint with the Washington state Office of the Insurance Commissioner at www.insurance.wa.gov or call 1-800-562-6900.

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

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

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

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

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

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "Plan") provided for You by Your employer. Your employer has chosen Regence BlueShield to administer claims for Your group health plan. Throughout this Booklet, Your employer may be referred to as the "Plan Sponsor."

EMPLOYER PAID BENEFITS

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

Because of their extensive experience and reputation of service, Regence BlueShield has been chosen as the Claims Administrator of Your Plan.

The following pages are the Booklet, the written description of the terms and benefits of coverage available under the Plan. This Booklet is effective January 1, 2020, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueShield and makes it void.

This Booklet is not the official Plan Document. If the Plan Document and this Booklet differ, the Plan Document will prevail. If Your Plan has a separate administrator (Plan Administrator), they also have a copy of the Plan Document.

The Plan is not subject to the Employee Retirement Income Security Act of 1974 as amended (ERISA).

Keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll And When Coverage Begins, When Coverage Ends, COBRA Continuation of Coverage, and Other Continuation Options sections, where applicable, the terms "You" and "Your" mean the Participant only). The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions section or where they are first used and are designated by the first letter being capitalized.

Using Your Booklet

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

You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network," and "Out-of-Network."

In-Network Benefit

Your Provider Network is: Eastside Health Network. To receive care at the lowest amount of out-of-pocket expense follow these steps:

- Select a Primary Care Provider from Your network for Yourself and each member of Your family. Contact Us if You need help finding a Primary Care Provider who can manage Your care.
- When You need care, contact Your Primary Care Provider first. He or she will treat You and determine if You need to seek more specialized care and may refer You to a Specialist, if necessary. Referrals are not required for specialty care, but Your Primary Care Provider can help You find the right In-Network Provider for Your condition.
- If You need to be admitted as an inpatient for care at a Hospital or clinic for non-emergent care, Your Primary Care Provider may handle all arrangements with the facility or may refer You to a Specialist who will make the necessary arrangements.

The In-Network level of benefits is available only if You see Providers in Your Provider network.

Out-Of-Network Benefit

When You use an Out-of-Network Provider, Your out-of-pocket expenses will generally be higher than seeing an In-Network Provider. An Out-of-Network Provider may bill You for any balances beyond the Deductible, Copayment and/or Coinsurance (sometimes referred to as balance billing).

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

ADDITIONAL ADVANTAGES OF PARTICIPATION

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator 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 the Claims Administrator's Web site, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:
  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
  - discover discounts on select items and services.*

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

CONTACT INFORMATION

- **Call Customer Service:** 1 (800) 376-7926 (TTY: 711) if You have questions, would like to learn more about Your Plan, have not received or have lost Your Plan identification card, or would like to request

written or electronic information. Phone lines are open Monday-Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.

- **Visit the Claims Administrator's Web site at: regence.com.**
- **For assistance in a language other than English,** call the Customer Service telephone number.
- **Call Case Management:** 1 (866) 543-5765 to request that a case manager be assigned to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers.
- **BlueCard® Program.** Call Customer Service to learn how to access care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.
- **CVS Caremark:** Customer Service: 1 (844) 380-8838 / 1 (800) 863-5488 (TTY). Claims Department: P.O. Box 52136, Phoenix, AZ 85072-2136.

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Understanding Your Benefits

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

MAXIMUM BENEFITS

Some benefits may have a specific Maximum Benefit. Benefits are covered until the specified Maximum Benefit (which may be a number of days, visits, services, dollar amount, or specified time period) has been reached.

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

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

DEDUCTIBLES

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

There are two Calendar Year Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. Calendar Year Deductibles are available on a per Claimant and a per Family basis. The In-Network and Out of Network amounts accrue separately and do not combine. For the Family Calendar Year Deductible, one Claimant will not contribute more than the individual Deductible amount.

Ambulance Services, Blood Bank and Emergency Room will apply toward the In-Network Deductible.

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

In addition, if Covered Services are incurred during the last three months of a Calendar Year and are applied toward the Deductible for that year, then any amount for Covered Services applied toward such Deductible during the last three months will be carried forward and applied toward the Deductible for the following year.

COPAYMENTS

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

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

Copayments applicable to prescription medications are located in the section titled Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet.

COINSURANCE

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

The Plan does not reimburse Providers for charges above the Allowed Amount. In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers may bill You for any balances over the Plan payment

level in addition to any Deductible, Copayment and/or Coinsurance amount (referred to as balance billing).

Coinsurance amounts applicable to prescription medications are located in the section titled Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet.

BALANCE BILLING

Balance billing occurs when You are billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services provided to You by an Out-of-Network Provider when the Out-of-Network Provider's billed amount is not fully reimbursed by the Plan. You will not be balance billed for 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. Any amounts You pay for emergency services or for non-emergency surgical or ancillary services will count toward Your Deductible and Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

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

There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. Calendar Year Out-of-Pocket Maximums are available on a per Claimant and a per Family basis. Out-of-Pocket expenses will apply toward both the In-Network and Out-of-Network Out-of-Pocket limit. For the Family Calendar Year Out-of-Pocket Maximum amount, one Claimant will not contribute more than the individual Out-of-Pocket Maximum amount.

Ambulance Services, Blood Bank, and Emergency Room will apply toward the In-Network Out-of-Pocket Maximum amount.

Amounts You pay for non-Covered Services and amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Out-of-pocket amounts applicable to prescription medications are located in the section titled Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet.

HOW BENEFITS RENEW

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

If Your Plan 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 plan year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement less any amount already satisfied under the previous plan during the same Calendar Year.

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

Medical Benefits

This section explains how Your Plan pays for Covered Services.

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

Some services may require preauthorization. Contracted Providers may be required to seek preauthorization from the Claims Administrator before providing some services for You. You will not be penalized if the Contracted Provider does not obtain preauthorization in advance from the Claims Administrator and the service is later determined to be not covered. Non-Contracted Providers are not required to obtain preauthorization prior to providing services. You may be liable for the cost of services provided by a Non-Contracted Provider if those services are not Covered Services nor Medically Necessary. You may request that a Non-Contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services. A comprehensive list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Web site at: https://www.regence.com/web/regence_provider/pre-authorization or by calling 1 (800) 376-7926.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). All covered benefits are subject to the limitations, exclusions and provisions of this Plan. A Health Intervention may be medically indicated or otherwise Medically Necessary, yet not be a Covered Service. In some cases, benefits or coverage may be limited to a less costly and Medically Necessary alternative item. See the Definitions section for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

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 wheelchair or breast pumps, 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 the Web site or contact Customer Service.

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

CALENDAR YEAR DEDUCTIBLES

In-Network
Per Claimant: $250
Per Family: $750

Out-of-Network
Per Claimant: $500
Per Family: $1,500

COPAYMENTS AND COINSURANCE

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

In-Network
Per Claimant: $1,250
Per Family: $2,750

Out-of-Network
Per Claimant: $2,500
Per Family: $5,500

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit.

For a complete list of services covered under this benefit, including information about how to access an approved commercial seller, obtaining breast pumps and instructions for obtaining reimbursement for new breast pumps purchased from an approved commercial seller, retailer, or other entity that is not a Provider, visit the Web site or contact Customer Service.

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

All Food and Drug Administration (FDA) approved contraceptive devices, products and services are covered under the Reproductive Health Care Services benefit.

All other Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury.

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

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

Immunizations – Adult

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

Immunizations – Childhood

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

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

Immunizations – Influenza, Measles, Mumps and Rubella

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

Immunizations for influenza, measles, mumps, and rubella. Any administration fees are also covered.

Immunizations – Expanded

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Immunizations, other than as covered under Immunizations – Adult or Immunizations – Childhood, or Immunizations – Influenza, Measles, Mumps and Rubella are covered, including for purposes of travel, occupation, or residency in a foreign country.

OFFICE VISITS – ILLNESS OR INJURY

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, You pay 0% of the Allowed Amount. **Payment for Commercial Driver's License Exam:** You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges. **Payment for Commercial Driver's License Exam:** You pay 0% of billed charges.

Office, home or Hospital outpatient department visits, and urgent care facility visits for treatment of Illness or Injury are covered. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (such as separate Facility Fees billed in conjunction with the office visit) are not considered an office visit.

PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and may be balance billed.

Professional services and supplies include the following:

Diagnostic Procedures

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

Medical Services and Supplies

Professional services, second opinions and supplies are covered, including the services of a Provider whose opinion or advice is requested by the attending Provider. Services and supplies also include those to treat a congenital anomaly, foot care associated with diabetes and Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Additionally, some general medical services and supplies, such as compression stockings, active wound care supplies, and sterile gloves, are covered when Medically Necessary. Reimbursement for covered medical supplies may be available when these new supplies are obtained from an approved commercial seller, even though that seller is not a Provider. Eligible new general medical supplies purchased through an approved commercial seller are covered at the 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 the Web site or contact Customer Service.

Professional Inpatient, Outpatient

The Plan covers professional inpatient and outpatient visits for Illness or Injury. If procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital or the procedures are performed outpatient at an In-Network Facility, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by In-Network and Out-of-Network Providers at the In-Network benefit level. The Plan will also cover outpatient laboratory services received from an Out-of-Network laboratory at the In-Network benefit level if ordered in the office by an In-Network Provider. If services were not covered at the In-Network level, as described above, please contact the Claims Administrator's Customer Service for further information and guidance.

Radiation Therapy, Respiratory Therapy and Chemotherapy

Radiation therapy, respiratory therapy, and chemotherapy services are covered. This benefit does not include services covered under the Your Prescription Medication Benefits Administered By CVS Caremark section at the end of this Booklet.

Radiology and Laboratory

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

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

Surgical Services

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

Therapeutic Injections

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

ACUPUNCTURE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: 60 visits per Claimant per Calendar Year	

Acupuncture visits are covered. Acupuncture visits apply to the Maximum Benefit limit for these services, including acupuncture visits that are applied toward any Deductible. For acupuncture to treat Substance Use Disorder Conditions or tobacco cessation withdrawal, refer to the Substance Use Disorder Services and Tobacco Use Cessation benefits in this Medical Benefits section.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, You pay 10% of the Allowed Amount.

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

AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

APPROVED CLINICAL TRIALS

If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered, subject to any Deductible, Coinsurance and/or Copayments and Maximum Benefits as specified in the Medical Benefits section.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

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

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

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

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

- An Investigational item, device, or service that is the subject of the Approved Clinical Trial;
- Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant; or

- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

BARIATRIC SERVICES

Office Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Bariatric Surgery

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Bariatric surgery to treat obesity is covered. Before You proceed with bariatric surgery, the Claims Administrator must evaluate and approve the surgery as meeting its published medical policy.

BLOOD BANK

Provider: All
Payment: After Deductible, You pay 10% of the Allowed Amount.

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

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Medically Necessary detoxification services are covered.

DIABETIC EDUCATION

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

Services and supplies for diabetic self-management training and education provided by Providers with expertise in diabetes are covered. Diabetic nutritional counseling and therapy is also covered.

DIALYSIS – INPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Inpatient services and supplies for dialysis not related to the Dialysis – Outpatient Program are covered.

DIALYSIS – OUTPATIENT

Initial Outpatient Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Outpatient limit: 42 treatments per Claimant	

Professional services, supplies, medications, labs and Facility Fees related to outpatient hemodialysis, peritoneal dialysis, hemofiltration and home services are covered during the first treatment period. For the purpose of this benefit the "first treatment period" will be three months (42 treatments) of hemodialysis treatment (or 30 days of peritoneal dialysis treatment). Dialysis treatments that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. If more than 42 treatments are necessary in the first treatment period, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. See the Supplemental Outpatient Treatment Period for coverage after the first 42 treatments in the first treatment period.

When Your Physician recommends dialysis, You should first contact the Claims Administrator to begin Case Management and confirm Your enrollment in the Supplemental Kidney Dialysis Program described below.

The Plan will pay regular Plan benefits when services are rendered outside the country, even if You have enrolled in the Supplemental Kidney Dialysis Program.

Supplemental Outpatient Treatment Period (Following Initial Outpatient Treatment Period)

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

For any subsequent outpatient dialysis beyond the first treatment period, the Plan will provide supplemental coverage as described above.

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

"Medicare allowed amount" is the amount that a Medicare-contracted provider agrees to accept as full payment for a covered service. This is also referred to as the provider accepting Medicare assignment.

Case Managed Dialysis and Supplemental Kidney Dialysis

Receive one-on-one help and support in the event Your Physician recommends dialysis. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most.

Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to make a referral to case management, call 1 (800) 376-7926.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Durable Medical Equipment must be rendered by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Applicable sales tax for Durable Medical Equipment and mobility enhancing equipment is also covered. Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Examples include oxygen equipment, wheelchairs, and insulin pumps and their supplies. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Reimbursement may also be available for new Durable Medical Equipment when obtained from an approved commercial seller, even though this entity is not a Provider. Eligible new Durable Medical Equipment purchased through an approved commercial seller is covered at the In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. Claims for the purchase of Durable Medical Equipment will be submitted to the plan in the locale in which the equipment was received. To find ways to access new Durable Medical Equipment, including how to access an approved commercial seller, visit the Web site or contact Customer Service. If You choose to access new Durable Medical Equipment through the Web site, the Claims Administrator may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan but are not insurance.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment for Emergency Care: After $200 Copayment per visit and Deductible, You pay 10% of the Allowed Amount. The Copayment applies to the facility charge, whether or not You have met the Deductible. However, the Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment for Emergency Care:** After $200 Copayment per visit and In-Network Deductible, You pay 10% of the Allowed Amount. The Copayment applies to the facility charge, whether or not You have met the Deductible. However, the Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.
Payment for Non-Emergency Care: After $200 Copayment per visit and Deductible, You pay 10% of the Allowed Amount. The Copayment applies to the facility charge, whether or not You have met the Deductible.	**Payment for Non-Emergency Care:** After $200 Copayment per visit and In-Network Deductible, You pay 40% of the Allowed Amount.

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations and treatment, routinely available ancillary evaluative services, and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition.

"Stabilization" means to provide Medically Necessary treatment:

- to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Claimant from a facility; and
- in the case of a covered female Claimant, who is pregnant, to perform the delivery (including the placenta).

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

If You are 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 level, contact Customer Service for an adjustment to Your claims.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

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

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

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

HEARING AIDS

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 0% of the Allowed Amount and You pay any balance of billed charges.
Limit: $500 per Claimant every three Calendar Years	

Hearing evaluations, hearing aids (and batteries), fittings, rentals, and repairs are covered when necessary for the treatment of hearing loss. For the purpose of this benefit hearing aid means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device. This coverage does not include routine hearing examinations or the cost of cords.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 0% of the Allowed Amount and You pay any balance of billed charges.
Limit: 130 visits per Claimant per Calendar Year for home health care visits and private duty nursing visits combined.	

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. Private duty nursing is also covered.

Home health care visits and private duty nursing visits apply to the Maximum Benefit limit for these services, including home health care visits and private duty nursing visits that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

HOSPICE CARE

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

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

Respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant is also covered.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Inpatient and outpatient services and supplies of a Hospital are covered for Illness and Injury (including prescription medications and services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary.

If You are admitted to 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 level, contact Customer Service for an adjustment to Your claims.

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

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

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

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

INFERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: $25,000 per Claimant per Lifetime	

Surgical and nonsurgical treatment for the correction of infertility is covered. This coverage includes assisted reproductive procedures (for example, in vitro fertilization, artificial insemination, or embryo transfer), regardless of infertility diagnosis, and cryogenic or other preservation, storage, and thawing (or comparable preparation) of egg, sperm or embryo. The Plan does not cover uterine transplants.

U.S. Food and Drug Administration (FDA) approved prescription medications indicated to treat infertility will be covered up to a $5,000 lifetime benefit limit. Keep in mind that Your Provider must write a prescription and it must be filled at a network pharmacy as specified in Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet. Additionally, there may be some prescription medications that are administered by a Provider in a medical office that may be limited to coverage under Your medical benefits.

NOTE: According to IRS guidance, fertility preservation (including egg freezing and tissue storage) will be treated as a taxable benefit. If You choose this option, be aware that the cost of the procedure and subsequent storage will be added as taxable wages to Your W-2. Consult with a tax advisor to determine how this might impact Your specific circumstances.

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

Surrogacy

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

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

Definitions

The following definition applies to this Maternity Care benefit:

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

MEDICAL FOODS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

MENTAL HEALTH SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Outpatient Office / Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Mental Health Services for treatment of Mental Health Conditions are covered, including Applied Behavioral Analysis (ABA) therapy services covered for treatment of Autism Spectrum Disorders when Claimants seek services from licensed Providers qualified to prescribe and perform ABA therapy services.

Services must meet the Claims Administrator's clinical criteria guidelines and Providers must submit individualized treatment plans and progress evaluations.

Marital and family counseling is also covered.

Definitions

The following definitions apply to this Mental Health Services benefit:

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

Mental Health Services means Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health

Provider for a covered diagnosis), and court ordered treatment (unless the treatment is determined by the Claims Administrator to be Medically Necessary).

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

NEURODEVELOPMENTAL THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies are covered under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled, if applicable, as explained in the Who Is Eligible, How to Enroll and When Coverage Begins section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a newborn child following birth including well-baby Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Nutritional counseling and therapy for all conditions, including obesity, is covered.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

Orthotic devices must be provided by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). In some cases, the Claims Administrator may limit benefits or coverage to a less costly and Medically Necessary alternative item.

Reimbursement may also be available for new orthotic devices when purchased new from an approved commercial seller, even though that seller is not a Provider. Eligible new orthotic devices purchased through an approved commercial seller are covered at the 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 the Web site or contact Customer Service. If You choose to access new orthotic devices through the Web site, the Claims Administrator may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

PALLIATIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: 30 visits per Claimant per Calendar Year	

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

PENILE PROSTHESES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Penile prostheses are covered, up to a maximum of two per Claimant per Lifetime, when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery, or an Injury to the genitalia or spinal cord, when other attempted treatment has been unsuccessful.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, mastectomy bras only for Claimants who have had a mastectomy, external or internal breast prostheses following a mastectomy and maxillofacial prostheses.

Hair prostheses or wigs are covered, up to a maximum of $100 per Claimant per Lifetime, to replace hair loss caused by radiation therapy or chemotherapy for a covered condition, or with a transgender diagnosis.

Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital inpatient care, Hospital outpatient care, or Ambulatory Surgical Center care) in this Medical Benefits section. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered.

RECONSTRUCTIVE SERVICES AND SUPPLIES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

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

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

REHABILITATION SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Inpatient limit: 60 days per Claimant per Calendar Year **Outpatient limit:** 60 visits per Claimant per Calendar Year	

Inpatient and outpatient rehabilitation services and accommodations to restore or improve lost function because of an Injury, Illness or disabling condition are covered. Rehabilitation services are physical, massage, occupational, and speech therapy services necessary to help get the body back to normal health or function, and include services such as massage when provided as a therapeutic intervention. Rehabilitation services apply to the Maximum Benefit limit for these services, including rehabilitation services that are applied toward any Deductible. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies for treatment required as a result of damage to, or loss of, sound natural teeth are covered, when such damage or loss is due to an accidental Injury. Injury resulting from biting and chewing is not covered. Treatment must be provided within 12 months of the date of the Injury if the Claimant is age 14 and older.

REPRODUCTIVE HEALTH CARE SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

The following FDA-approved contraceptive devices, products, and services are covered when provided by a Physician or Practitioner:

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

NOTE: Additional contraceptives are covered as specified in Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet.

RETAIL CLINIC OFFICE VISITS

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

SKILLED NURSING FACILITY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: 33 spinal manipulations per Claimant per Calendar Year	

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

SUBSTANCE USE DISORDER SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

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

Definitions

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

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

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

Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined by the Claims Administrator to be Medically Necessary).

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

For coverage of detoxification services and Emergency Medical Conditions, see the Detoxification and Emergency Room benefits of this Booklet.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

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

"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.

Coverage includes night guards. Night guard services provided by a dentist are covered at the In-Network benefit level.

TOBACCO USE CESSATION

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

Tobacco use cessation expenses (in addition to the cost of sales tax) not covered under the Preventive Care and Immunizations benefit are covered under this Tobacco Use Cessation benefit, including over-the-counter nicotine patches, lozenges, and gum. Acupuncture and hypnotherapy to ease nicotine withdrawal are also covered.

TRANSGENDER SERVICES

The following transgender benefits, based on the Standards of Care published by the World Professional Association for Transgender Health (WPATH), are covered. All transgender services that meet the prior approval requirements are subject to the most current Standards of Care published by WPATH. Any services listed in the most recent WPATH Standards of Care and WPATH Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the United States would be covered. Case management services are available to provide assistance with pre-authorization requirements, locating providers and researching additional resources. To learn more or to make a referral to case management, call 1 (866) 543-5765. There is no lifetime maximum for covered transgender services as outlined in this document and in the WPATH Standards of Care.

COVERED MEDICAL BENEFITS
Mental Health

Male to Female or Female to Male:
Covered Services
- Visits for purposes of assessment, diagnosis, referral letters and treatment of gender dysphoria, transsexualism, or gender identity disorder

Hormones (Category of Prior Approval Required – A & E)

Male to Female or Female to Male:
Covered Services
- Hormone therapy, as covered in the section titled Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet
- Laboratory tests to monitor hormone levels

Breast/Chest Surgery (Category of Prior Approval Required – A & B)

Male to Female:
Covered Services
- Breast augmentation
- Nipple/areola complex reconstruction

Female to Male:
Covered Services
- Mastectomy
- Mastectomy with liposuction of the chest wall
- Nipple/areola complex reconstruction

Genital Surgery (Category of Prior Approval Required – A & C)

Male to Female:
Covered Services
- Penectomy
- Orchiectomy
- Clitoroplasty
- Labiaplasty (of labia minora and majora)
- Vaginoplasty (Vaginoplasty may be performed with penile inversion technique, intestinal vaginoplasty, or with the use of skin grafts/flaps)
- Urethroplasty

Female to Male:
Covered Services
- Scrotoplasty
- Vulvectomy
- Colpectomy/vaginectomy
- Phalloplasty (with or without urethral lengthening/urethroplasty), including Glansplasty
- Metoidioplasty (with or without urethral lengthening/urethroplasty)
- Hysterectomy/oophorectomy (no mental health assessment or letters are required for hysterectomy/oophorectomy alone, but these procedures may be performed in conjunction with genital reconstruction in some cases)
- Staged (secondary) procedures following phalloplasty/metoidioplasty: these procedures do not require additional mental health assessments (i.e., letters)
- Secondary procedures (following phalloplasty or metoidioplasty): testicular implants, urethroplasty
- Secondary procedures (following phalloplasty): penile prosthesis, urethroplasty

Hair Removal (Category of Prior Approval Required – A & B)

Male to Female or Female to Male:
Covered Services
- Laser
- Electrolysis
- Topical anesthetic

Hair Grafts (Category of Prior Approval Required – A & B or A & D)

Male to Female:
Covered Services
- Hair grafts

Facial Reconstruction/Contouring (Category of Prior Approval Required – A & B or A & D)

Male to Female:
Covered Services
- Thyroid chondroplasty
- Brow lift
- Forehead contouring
- Malar (cheek) implants
- Jaw and/or chin re-shaping
- Lip shortening
- Scalp (hairline) advancement
- Rhinoplasty

Female to Male:
Covered Services
- Augmentation thyroid chondroplasty (Thyroid cartilage augmentation)
- Chin implant and/or genioplasty
- Jaw implant

Body Reconstruction/Contouring (Category of Prior Approval Required – A & B or A & D)

Male to Female:
Covered Services
- Lipofilling of hips, thighs, buttocks
- Buttocks implant

Female to Male:
Covered Services
- Mons lift/mons reduction
- Pectoral implants
- Calf implants

Voice (Category of Prior Approval Required – A)

Male to Female or Female to Male:
Covered Services
- Voice therapy
- Voice modification surgery – only after voice therapy has been proven ineffective as attested to by providing voice therapist.

Initial/Pre-Op, Preventative and Follow-Up Care

- Initial doctor physical exams, visits, and pre-op tests
- Post-operative follow-up visits with surgeon(s) or primary care provider(s) as needed to ensure proper healing and adjustment.

- Routine medical care, with periodic laboratory tests to monitor hormone levels (quarterly for the first 12-18 months and annually thereafter) and annual physical examinations that are respectful of and attentive to the particular physical make-up of transgender, transsexual, and gender nonconforming bodies.
- Prescription drugs, as covered under the section titled Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet, and any mental health services as an individual prepares for and recovers from gender reassignment surgery.

PRIOR APPROVAL REQUIREMENTS:

Category A: Must have received a clinical diagnosis of gender dysphoria, transsexualism, or gender identity disorder.

Category B: One letter of referral for surgery from a licensed mental health professional, or other health professional who is trained in behavioral health. The referral letter must include:

- The individual's general identifying characteristics;
- Results of the individual's psychosocial assessment, including any diagnoses;
- The duration of the mental health professional's relationship with the individual, including the type of evaluation and therapy or counseling to date;
- Clinical rationale for supporting the individual's request for surgery;
- A statement about the fact that informed consent has been obtained from the individual;
- A statement that the referring health professional has reviewed the WPATH Standards of Care section "Tasks Related to Assessment and Referral"; and
- A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

Category C: Must have reached the legal age of majority set by the state of residence. (18 years old in Washington State). Two letters of referral for surgery, dated within the past 12 months, from two licensed mental health professionals. One referral should be from the individual's psychotherapist, and the second referral should be from a mental health professional who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (if practicing within the same clinic) may be sent. The referral letters must include:

- The individual's general identifying characteristics;
- Results of the individual's psychosocial assessment, including any diagnoses;
- The duration of the mental health professional's relationship with the individual, including the type of evaluation and therapy or counseling to date;
- Clinical rationale for supporting the individual's request for surgery;
- A statement about the fact that informed consent has been obtained from the individual;
- A statement that the referring health professional has reviewed the WPATH Standards of Care section "Tasks Related to Assessment and Referral"; and
- A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

Category D: You must have had genital or breast/chest surgery to change gender within the past two years.

Category E: Prescription from a doctor for hormone therapy (for replacement or maintenance)

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

- cornea
- heart
- lung
- liver
- kidney
- pancreas
- small bowel
- multivisceral
- islet cell
- hematopoietic stem cell

Hematopoietic stem cells can be collected from either the bone marrow or the peripheral blood and may involve the following donors: autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions).

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

Donor Organ Benefits

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

VIRTUAL CARE

Virtual care services from a Provider are covered. Virtual care refers to the utilization of store and forward, telehealth and, telemedicine services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment, or management of a covered medical condition. To learn more about how to access virtual care services, please visit the Web site or contact Customer Service.

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: After $10 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Store and forward services are covered. For the purpose of this benefit, "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. Store and forward services do not include, for example, non-secure HIPAA compliant telephone, fax, short message service (SMS) texting or e-mail communication. Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth – Doctor on Demand

Provider: Doctor on Demand	Provider: Out-of-Network
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 100% of the billed charges. Your payment will not be applied toward any Deductible or Out-of-Pocket Maximum.

Telehealth – Regence

Provider: In-Network	Provider: Out-of-Network
Payment: After $10 Copayment per visit, You pay 0% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Telehealth services are covered. For the purpose of this benefit, "telehealth" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when you are not in a healthcare facility.

Telemedicine

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Telemedicine services are covered. For the purpose of this benefit, "telemedicine" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when you are at a healthcare facility.

Care Management and Wellness Programs

Because of Regence's involvement as the Claims Administrator, You have access to the following group-sponsored care management and wellness programs. Your employer has chosen to provide these benefits to You. To the extent any part of these programs is also a benefit under the Medical Benefits or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

CASE MANAGEMENT

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

To learn more or to make a referral to case management, call 1 (866) 543-5765.

ALTERNATIVE BENEFITS

Alternative benefits means benefits for services or supplies that are not otherwise covered under the Plan, but for which the Claims Administrator may approve coverage after case management evaluation and analysis. The Plan may cover alternative benefits through case management if the Claims Administrator determines that alternative benefits are Medically Necessary and will result in overall reduced covered costs and improved quality of care. Before coverage of alternative benefits and before the processing of claims for alternative benefits, the Claims Administrator, You or Your legal representative and, if required by the Claims Administrator, Your Physician or other Provider, must agree in writing to the specific terms and conditions for payment. Alternative benefits are approved on a case-specific basis only. The fact that the Plan may cover alternative benefits for You does not set any precedent for coverage of continued or additional alternative benefits for You, or anyone else covered under the Plan.

REGENCE CONDITION MANAGER

Regence Condition Manager is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claims Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help You get on track with Your care--and stay there. They can help You understand the care plan You've developed with Your Physician, and make smarter choices for better health.

To learn more, call 1 (866) 543-5765.

REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include a health assessment, incentives to reward participation in healthy activities and online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals. To get started and access the resources available, visit **regence.com**.

REGENCE ADVICE 24

Registered nurses are available 24/7 to answer Your health-related questions and help You make informed decisions about when, where and if to seek care. If You're not sure whether to visit the emergency room, see Your doctor or treat Your condition at home, the nurses are there, day or night.

Regence Advice 24 nurses have access to information about more than 5,500 health topics to ensure You receive the right care.

Call the Advice 24 hotline any time-24 hours a day, seven days a week at 1 (800) 267-6729.

General Exclusions

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

PREEXISTING CONDITIONS

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

SPECIFIC EXCLUSIONS

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

Activity Therapy

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

Certain Therapy, Counseling, and Training

Educational, vocational, social, image, milieu, or marathon group therapy, premarital counseling, IAP/EAP services; job skills or sensitivity training.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Cosmetic Services and Supplies

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

Counseling

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

Custodial Care

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

Dental Services

Dental Services and supplies provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth. This exclusion does not apply to dental services described under the Temporomandibular Joint (TMJ) Disorders benefit or Repair of Teeth benefit.

Expenses Before Coverage Begins or After Coverage Ends

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

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

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

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

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

Infertility Treatment
Except as provided under the Infertility Treatment benefit in this Booklet, the Plan does not cover treatment of infertility, including but not limited to surgery and uterine transplants.

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

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

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

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

Obesity or Weight Reduction/Control
Except as may be specifically provided in the Booklet, the Plan does not cover medical treatment, medications, surgical treatment (including revisions, reversals, and treatment of complications), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

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

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

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

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

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

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
The Plan does not cover self-help, non-medical self-care, training programs, including:

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

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

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

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

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

Sexual Dysfunction
Treatment, services and supplies (including medications) for or in connection with sexual dysfunction, regardless of cause, except for covered Mental Health Services and penile prosthesis when impotence is caused by a covered medical condition.

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

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

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

Vision Care
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.

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

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

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

In-Network Provider Claims and Reimbursement

You must present Your Plan identification card to an In-Network Provider, and furnish any additional information requested. The Provider will give the Claims Administrator the information needed to process Your claim.

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

Out-of-Network Provider Claims and Reimbursement

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

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

The Claims Administrator's standard policy is to make payment for Out-of-Network Provider claims by issuing a joint payee check to both the Claimant and the Provider or, with submission of sufficient documentation that the Claimant has already "paid in full", on a check issued solely to the Claimant. However, in some situations the Claims Administrator may choose to pay the nonparticipating Provider directly by check issued solely to the Provider.

Out-of-Network Providers may not agree to accept the Allowed Amount as payment for Covered Services. You 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, Copayment and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges, as determined by the Claims Administrator, or as otherwise required by law.

Timely Filing of Claims

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

Ambulance Claims

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

Claims Determinations

Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken. However, this 30-day period may be extended by an additional 15 days when action cannot be taken on the claim due to lack of information or extenuating circumstances. You will be notified of the extension within the initial 30-day period and provided an explanation why the extension is necessary. If additional information is required to process the claim, You will be allowed at least 45 days to provide it. If the Claims Administrator does not receive the requested information within the time allowed, the claim will be denied.

OUT-OF-AREA SERVICES

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

The Claims Administrator covers health care received outside of the Claims Administrator’s Service Area. As used in this Out-of-Area Services provision, "Out-of-Area Covered Services" means Covered Services obtained outside the Claims Administrators Service Area. Out-of-Area Covered Services will be provided at the Out-of-Network benefit level specific in the Booklet, except that emergency room services will be provided at the In-Network benefit level.

When You receive care outside of the Claims Administrators Service Area, You will receive it from one of two kinds of providers. Most providers ("Participating Providers") contract with the local BlueCross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("nonparticipating Providers") don’t contract with the Host Blue. How payment is made to both types of providers is explained below:

BlueCard Program

Under the BlueCard Program, when Out-of-Area Covered Services are received within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what was agreed to in the Administrative Services Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program enables You to obtain Out-of-Area Covered Services as defined above, from a health care Provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the Out-of-Area Covered Services provided to You, so there are no claim forms for You to fill out. You will be responsible for any Out-of-Network Deductible, Coinsurance and Copayments as specific in the Booklet. Please contact the Claims Administrator within 24 hours of admission to a Hospital so that Your care can be coordinated.

Emergency Care Services: If You experience an Emergency Medical Condition while traveling outside the Claims Administrators’ Service Area, go to the nearest emergency room.

When Out-of-Area Covered Services are received outside the Claims Administrator’s Service Area and the claim is processed through the BlueCard Program, the amount You pay for Out-of-Area Covered Services is calculated based on the lower of:

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

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

Estimated pricing and average pricing also take into account adjustments to correct for over-or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price the Claims Administrator uses for the Claimant's claim because they will not be applied after a claim has already been paid.

Nonparticipating Providers Outside the Claims Administrator's Service Area

- Your Liability Calculation. When Out-of-Area Covered Services are provided by nonparticipating Providers, the amount the Claimant pays for such services will normally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Claimant may be liable for the difference between the amount that the nonparticipating Provider bills and the payment that is made for the Out-of-Area Covered Services as set forth in this Booklet. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.
- Exceptions. In certain situations, other payment methods may be used, such as billed covered charges, the payment that would have been made if the health care services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment to determine the amount that will be paid for services provided by nonparticipating Providers. In these situations, the Claimant may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Out-of-Area Covered Services as set forth in this Booklet.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

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

If You need medical assistance services (including locating a doctor or Hospital) outside the United States, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

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

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

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for covered healthcare services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the Claims Administrator, the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

CLAIMS RECOVERY

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

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

This section explains how the Plan treats 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 the Plan.

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 the Plan retains 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. The Plan’s 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 the Plan’s right of subrogation. When this Plan pays health care benefits for expenses incurred due to Third Party Injuries, the Plan 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. The Plan may proceed against any party with or without Your consent.

By accepting benefits under this Plan, You also specifically acknowledge the Plan’s 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, the Plan has 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. The Plan’s right of reimbursement is cumulative with and not exclusive of the Plan’s subrogation right and the Plan 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.

The Plan will not exercise their 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 the Plan has advanced, the Plan may choose, in their 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 the Plan 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 the Plan and do whatever is necessary to secure their rights of subrogation and reimbursement under this Booklet. In addition, You or Your representative agrees to do nothing to prejudice the Plan’s 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 the Plan and You have not yet received recovery from the responsible third party, the Plan 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 the Plan, up to the amount of benefits the Plan 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 the Plan’s right is satisfied or released.
- Further, You or Your representative give the Plan 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 the Plan 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, the Plan may recover any benefits they have advanced for any Injury or Illness through legal action against You and/or Your agent or attorney.
- If the Plan pays benefits for the treatment of an Illness or Injury, they will be entitled to have the amount of the benefits the Plan has paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which the Plan has 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 the Plan advances are solely to assist You. By advancing such benefits, the Plan is not acting as a volunteer and is not waiving any right to reimbursement or subrogation.

The Plan may recover to the extent permitted by law, the full cost of all benefits paid by this Plan under this Booklet without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. You may incur attorney's fees and costs in connection with obtaining recovery. If this Plan is not subject to ERISA, the Plan 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 the Plan. If this Plan is subject to ERISA, You may request and the Plan 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 the Plan to less than the full amount of benefits paid by the Plan. In the event You or Your representative fail to cooperate with the Plan, You shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the Plan 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 the Plan uses 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 the Plan and motor vehicle insurance has not yet paid, the Plan may advance benefits for Covered Services as long as You agree in writing:
  - to give the Plan information about any motor vehicle insurance coverage which may be available to You; and
  - to otherwise secure the Plan’s rights and Your rights.
- If the Plan has paid benefits before motor vehicle insurance has paid, the Plan is entitled to have the amount of the benefits the Plan has paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of You held in trust for the Plan. The amount of benefits the Plan is entitled to will never exceed the amount You receive from all insurance sources that fully compensates You for Your loss and the Plan 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, the Plan 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 the Plan 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, the Plan may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for the Plan 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, the Plan 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 the Plan to less than the full amount of benefits paid by the Plan. If this Plan is subject to ERISA, You may request and the Plan 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 the Plan to less than the full amount of benefits paid by the Plan.

MAINTENANCE OF BENEFITS

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

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

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

Definitions

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

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

- Other Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

- Other Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

- For a child whose parents are married or are living together, whether or not they have ever been married:
  - The plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
  - If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
- For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
  - If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
  - If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
  - If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    The plan covering the Custodial Parent, first;

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

    The plan covering the noncustodial parent, third; and then

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

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

rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

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

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

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

Effect on the Benefits of this Plan

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

For example, say You are employed by the Plan Sponsor and You cover Yourself and Your spouse under This Plan, and Your spouse is also covered under his or her employer's plan. If Your spouse incurs an expense covered under both plans and Your spouse's plan is the Primary Plan, This Plan, when paying as the Other Plan, would either pay the amount which when added to the Primary Plan's payment would equal the amount This Plan would have paid had it been the Primary Plan or nothing if the Primary Plan's payment exceeded the amount This Plan would have paid had it been the Primary Plan.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

will need to submit Your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

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

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration qualify for a level of Expedited Appeal and are described separately later in this section.

Appeal information specific to prescription medications is located in Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: Appeals, Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator at 1 (800) 376-7926.

Each level of Appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are appealing). You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

If Your health could be jeopardized by waiting for a decision under the regular Appeal process, an expedited Appeal may be requested. See Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of healthcare professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

Second-Level Appeals

Second-level Appeals are reviewed by the Claims Administrator employee or employees who were not involved in, or subordinate to anyone involved in, the initial or the first-level decision. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available for issues involving medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or the determination that a treatment is Investigational), but only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if the Claims Administrator has failed to adhere to all claims and internal Appeal requirements. Voluntary External Appeals must be requested within four months of Your receipt of the notice of the prior adverse decision.

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will make its decision and provide You with its written determination within 45 days after their receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

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

EXPEDITED APPEALS

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

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

First-Level Expedited Appeal

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by the Claims Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. A written notification of the decision will be mailed to You within three calendar days of the verbal notification.

Voluntary Expedited External Appeal - IRO

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

The Claims Administrator coordinates voluntary expedited external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. Verbal notice of the IRO's decision will be provided to You and Your Representative by the IRO as soon as possible after the decision, but no later than within 72 hours of its receipt of Your request, followed by written notification within 48 hours of the verbal notification. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

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

INFORMATION

If You have any questions about the Appeal process outlined here, contact Customer Service at 1 (800) 376-7926 or write to Customer Service at the following address: Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

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

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

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

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

Representative means someone who represents You for the Appeal. The Representative may be an attorney, Your authorized Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is an unmarried and dependent child and is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. 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 or Your treating Provider only.

Eligibility Appeals

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

A Benefits, Payroll and Retirement Operations staff member will review Your appeal and notify You of the eligibility determination within these time frames:

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if You are notified that an extension is necessary);
- within 20 days for post-service appeals (within 40 days if You are notified that an extension is necessary); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If Your eligibility appeal is denied by King County, the notice will include the Plan provision behind the decision and advise You of Your right to obtain free copies of relevant documentation.

Benefits, Payroll and Retirement Operations has sole discretionary authority to determine benefit eligibility under the Plan, and its decision is final and binding. In reviewing Your claim, Benefits, Payroll and Retirement Operations applies the Plan terms and uses its discretion in interpreting Plan terms. Benefits are paid only if You meet the eligibility and participation requirements and Benefits, Payroll and Retirement Operations determines that You're entitled to benefits.

If You believe Your eligibility appeal was denied because relevant information or documents weren't considered, Benefits, Payroll and Retirement Operations offers You the option of filing an eligibility appeal addendum within 60 days after You receive the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits, Payroll and Retirement Operations manager.

The manager will review the additional information You provide, consult with appropriate county personnel and notify You in writing of the eligibility determination. The notice will indicate the specific Plan provision behind the decision and advise You of Your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. The manager's decisions are final and binding.

If You disagree with Your eligibility appeal determination, You may file a grievance with Your union or initiate legal action. Any legal action must be taken within two years of the date You or Your dependent is denied Plan participation, or You forfeit Your right to legal action.

Who Is Eligible, How to Enroll and When Coverage Begins

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

As a King County Transit ATU 587 employee, You are eligible to participate in either the Part-time Partial Benefits Plan, the Part-time Full Benefits Plan, or the Full-time Full Benefits Plan. Eligibility is determined by an agreement between King County and Amalgamated Transit Union Local 587. If You have any questions regarding eligibility, contact Your base chief.

When You become eligible, You are provided enrollment materials.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

Part-time Partial Benefits Plan

You become eligible for the Partial Benefits Plan on the first of the month following Your hire date or qualification date, whichever is later. Your hire and qualification dates are determined by Your department. If the later of Your hire date or qualification date is the first of the month, You become eligible that same day.

You may purchase medical coverage for Yourself and Your eligible dependents. You must elect medical coverage for Yourself in order to elect any dependent coverage.
The cost of Your medical coverage is partially subsidized by King County, but dependent coverage isn't.

Part-time Full Benefits Plan

Under the Full Benefits Plan, You receive King County-paid medical coverage for Yourself and the eligible dependents You enroll. You become eligible for the Full Benefits Plan when any of the following occurs:

- You pick a work assignment of four or more hours during the fall pick. Your coverage on the Full Benefits Plan begins October 1 of that year, and continues through December 31 of the following year.
- You pick a work assignment of four or more hours during any other pick. Your coverage on the Full Benefits Plan begins on the first day of the month after You begin working that assignment and continues through December 31 of the same year.
- You receive 1,040 or more paid hours in the 26 pay periods ending with the pay period that includes June 30. Your coverage on the Full Benefits Plan becomes effective January 1 of the following year and continues through December 31 of the same year.
- You pick a work assignment of four or more hours at least once per year and You have 10 or more years of part-time seniority on December 31 of the previous year. Your coverage on the Full Benefits Plan begins on the first day of the month after You begin working that assignment and continues through December. 31 of the following year.

  Note: A "move-up" is not considered a "pick."

Average pay time is used to determine whether an assignment is four or more hours. If the average pay time is different than the picked time, it is noted on the pick postings. The average pay time must equal four or more hours to guarantee coverage on the Full Benefits Plan. An average pay time of three hours and 59 minutes or less does not guarantee coverage on the Full Benefits Plan, regardless of actual time worked.

Paid hours include hours worked (including overtime) and paid time off (including vacation and sick leave) as a part-time transit operator, although no credit is given for hours paid as a part-time transit operator trainee. If You're detailed out of classification during the review period, the hours paid in the out-of-class position are included. You receive credit for a picked assignment for the first 30 days of unpaid union leave accrual. Cash-outs and premium pay aren't included, and no credit is given for job-injury time-loss.

Full-time Full Benefits Plan

Under the Full-time Full Benefits Plan, You receive King County-paid medical coverage for Yourself and the eligible dependents You enroll. You become eligible for the Full-time Full Benefits Plan when any of the following occurs:

You are hired or transferred into Full-Time Operator position.

Dependents

Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Eligible dependents include:

- Your legal spouse.
- Your Washington state registered domestic partner as defined in the Washington State statute.
- Your children, up to age 26, regardless of marital status or dependent status. Children includes stepchildren and all children legally placed in your home (e.g., adopted designated wards, foster children, children placed with you as their legal guardian.

If You do not enroll eligible dependents now, You must wait until the next Annual Enrollment period, unless You experience a qualifying life event (see Special Enrollment section) or become eligible for a new benefits Plan.

Upon the initial enrollment of any dependent, You will be required to provide documentation to substantiate Your dependent (e.g., a marriage license to prove a spouse or birth certificate to prove a dependent child).

Tax implications for domestic partner health coverage: When You cover a state-registered domestic partner and/or Your domestic partner's children on Your medical, dental, or vision plan, the IRS taxes You on the value of the coverage. For more information, go to kingcounty.gov/benefits >Health Benefits>Benefit costs>Domestic Partner Rates.

If You and Your spouse/state-registered domestic partner are both King County employees:

- You may not cover each other as dependents on the medical plan.
- You may both cover Your children on Your medical plans; however, with coordination of benefits, there are limited extra benefits.
- Full-time and part-time full benefits employees: You may waive medical coverage and be covered as a dependent. You receive the extra $65 per month for opting out of medical coverage (Employees in the part-time/partial-pay benefit program do not receive the $65).

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

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request to the Claims Administrator. Application for enrollment of a new child by birth, adoption or Placement for Adoption must be made within 60 days of the date of birth, adoption or Placement for Adoption 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 Plan will be provided for a newborn child for up to 21 days following birth when delivery of the child is covered under the Plan. Such benefits will not be subject to enrollment requirements for a newborn as specified here, or the payment of a separate charge for coverage of the child. Coverage, however, is subject to all provisions, limitations and exclusions of the Plan. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn.

SPECIAL ENROLLMENT

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

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

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your state-registered domestic partner) and any eligible children are eligible to enroll for coverage under the Plan within 30 days from the date of the qualifying event (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
  - an employer's contributions to that other plan are terminated;
  - exhaustion of federal COBRA or any state continuation; or
  - loss of eligibility, for instance, due to legal separation, divorce, termination of state-registered domestic partnership, death, termination of employment or reduction in hours, or meeting or exceeding the lifetime limit on all benefits of a former plan.
- You and/or Your eligible dependent lose coverage due to no longer residing, living, or working in the service area of that coverage (and, if the coverage is in the group market, no other benefit package was available through the sponsoring entity).
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

If You are already enrolled or if You declined coverage when first eligible and subsequently have the following qualifying event, You (unless already enrolled), Your spouse (or Your state-registered domestic

partner) and any eligible children are eligible to enroll for coverage under the Plan within 60 days from the date of the qualifying event:

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

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

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

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

RETIREE ELIGIBILITY

If You have County health coverage on Your last day of employment, it continues through the last day of the month in which You leave. When County-paid coverage ends and You begin drawing a retirement pension, You and Your covered dependents can pay to continue coverage under the Retiree Medical Plan if You meet **all** of the following qualifications:

- You have County health benefits on Your last day of employment.
- You have been a King County employee for at least five years of cumulative service.
- You are not entitled to Medicare.
- You are not covered under another group medical plan.
- You meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or Seattle City Employees' Retirement System (applies only if You elected to remain under the City of Seattle system by formal agreement between the County and City).

To qualify for Retiree Medical, you must **retire** from King County. Retirement is defined as:

"Retiring as a result of length of service, which means an employee is eligible, applies for, and begins drawing a pension benefit from LEOFF, PERS Defined Benefit Plan, PSERS or the Seattle City Employees' Retirement System (for County employees who were formally grandfathered with continued participation in that plan) immediately upon terminating from County employment."

When Coverage Ends

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

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

AGREEMENT TERMINATION

If the Agreement is terminated or not renewed, claims administration by Regence ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed (except, if agreed between the Plan Sponsor and Regence, Regence may administer certain claims for services that Claimants received before that termination or nonrenewal).

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 Beneficiaries on the last day of the month in which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the continuation of coverage provisions.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

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

NONPAYMENT

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

FAMILY AND MEDICAL LEAVE

If Your employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period as outlined in Federal law.

During the FMLA leave, You must continue to make payments for coverage through the Plan Sponsor on time (as applicable). The provisions described here will not be available if the Plan terminates.

If You and/or Your Beneficiaries elect not to remain enrolled during the FMLA leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan on the first day of the month following Your return to work date (unless You return on the first day of the month in which case benefit coverage begins on the date of return to work). A person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

FAMILY AND MEDICAL LEAVE - OTHER

If Your employer grants You a leave of absence under eligible federal, Washington State or King County family medical leave laws you may be entitled to continued coverage under this provision only to the extent You are eligible. You and Your Beneficiaries will remain eligible to be enrolled under the Plan during any period of applicable family and medical leave laws that require an offer of benefits and/or when in a paid leave status.

LEAVE OF ABSENCE WITHOUT PAY

If You are granted a leave of absence without pay, You may continue to receive coverage for up to 30 calendar days. After 30 calendar days has been exhausted, Your coverage ends unless You return to work, enter a paid status or are eligible for a family and medical leave law that provides medical benefits.

A leave of absence without pay is defined as a leave of absence that is unpaid and is not eligible for coverage under any applicable Federal, Washington State, or King County family medical leave law. Examples of applicable laws include FMLA, KCFML, WFLA, WFCA (King County Code 3.12.250). 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 Plan Sponsor's employment records. A leave can be granted for any reason acceptable to Your employer.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

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

Divorce or Annulment

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

Death of the Enrolled Participant

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

Termination of Washington State Registered Domestic Partnership

If Your state-registered domestic partnership terminates after the Effective Date (including any change in status such that You and Your state-registered domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the state-registered domestic partner and the state-registered 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 state-registered domestic partnership. You are required to provide notice of the termination of a state-registered domestic partnership within 30 days of its occurrence. This termination provision does not apply to any termination of state-registered domestic partnership that occurs as a matter of law because the parties to the state-registered domestic partnership enter into a marriage (including any entry into marriage by virtue of an automatic conversion of the state-registered domestic partnership into a marriage).

Loss of Dependent Status for an Enrolled Child

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

OTHER CAUSES OF TERMINATION

Claimants may be terminated for any of the following reasons. However, it may be possible for them to continue coverage under the Plan according to the continuation of coverage provisions.

Fraudulent Use of Benefits

If You or Your Beneficiary engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan will terminate for that Claimant.

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional misrepresentation of material fact or fraud regarding a Claimant (including, but not limited to, a person

who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan Sponsor), any action allowed by law or contract may be taken, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries 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 state-registered domestic partner terminate the domestic partnership;
- You become entitled to Medicare benefits; or
- Your Beneficiary 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 Beneficiaries under certain conditions if You are retired and Your employer files for bankruptcy.)

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

General Rules

Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation coverage, plus an administration fee, even if the Plan Sponsor contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights under COBRA, You or Your Beneficiaries must inform the Plan Sponsor in writing within 60 days of:

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

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

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms described in the Booklet and claims under the Plan for services provided on and after the date coverage ends will not be paid.

Notice

The complete details on the COBRA Continuation provisions outlined here are available from the Plan Sponsor.

After You and/or Your Beneficiaries' exhaust COBRA continuation coverage, an Individual policy may be available.

Other Continuation Options

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

Medicare Supplement or Individual Contract

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

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

If the Agreement terminates and the Plan Sponsor transfers its health care plan to another contract with the Claims Administrator or to another carrier and You are covered under that plan, this continuation option does not apply.

Strike, Lockout or Other Labor Dispute

If Your compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, You may continue coverage under the Plan for Yourself and Your Beneficiaries during the dispute for a period not exceeding six months, by making the necessary payments for Your coverage through the Plan Sponsor. This provision will not apply if You and Your Beneficiaries 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 cost, including any part usually paid by the Plan Sponsor, directly to the union or trust that represents You. And the union or trust must continue to pay the Claims Administrator the payments according to the Agreement. This six months of continued coverage is instead of and not in addition to any continuation of coverage provisions of the Plan.

General Provisions and Legal Notices

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

CHOICE OF FORUM
Any legal action arising out of the Plan benefit option described herein must be filed in a court in the state of Washington.

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

PLAN SPONSOR IS AGENT
The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of the Claims Administrator. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan Sponsor 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 Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Booklet.

LIMITATIONS ON LIABILITY
In all cases, You have the exclusive right to choose a health care Provider. Since neither the Plan nor the Claims Administrator provides any health care services, neither can 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 employees nor agents of the Plan or the Claims Administrator. Neither the Claims Administrator nor the Plan is responsible for the quality of health care You receive, except as provided by law.

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

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

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

NOTICES

Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan Sponsor will be addressed to the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address (COA) form for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Administrator or Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to the Claims Administrator's Customer Service address; however, any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

NOTICE OF PRIVACY PRACTICES

A Notice of Privacy Practices is available by calling Customer Service or visiting the Claims Administrators Web site.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used in accordance with the Claims Administrator's Notice of Privacy Practices. To request a copy, visit the Web site or contact Customer Service.

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

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

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

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);

- laboratory reports; and
- medical records.

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

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

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 the Claims Administrator to receive information related to these health conditions.

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

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

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

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

TAX TREATMENT

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

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

Definitions specific to prescription medications are located in Your Prescription Medication Benefits Administered By CVS Caremark at the end of this Booklet.

PROVIDER DEFINITIONS
For Providers of care, the following terms apply:

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

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

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

Out-of-Network Provider means Providers that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over the Claims Administrator's payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services. However, inside the Service Area, a Contracted Provider that has signed a participating contract with the Claims Administrator, and is otherwise an Out-of-Network Provider under this Plan, will not bill You for balances over the Claims Administrator's payment level for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Out-of-Network Providers include any Provider that is not one of the Claims Administrator's identified Centers of Excellence for the particular therapy.

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

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

Primary Care Provider means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who has a specialty type of general practice, family practice, internal medicine, pediatrics, geriatrics, OB/GYN and obstetrics, preventive medicine, adult medicine, women’s health care practitioner. Primary Care Provider also means any physician assistant, nurse practitioner or advance registered nurse practitioner if their primary specialty is one of the above and they are working under the license of an M.D. or D.O. in these specialties. This definition does not include naturopaths. Selection of a particular Provider to coordinate referrals or to receive primary care services is not required. You may change the Provider of Your care (including primary care) at any time by consulting a different Provider. If the Claims Administrator terminates the contract of Your Primary Care Provider without cause, the Claims Administrator will continue to cover Your Primary Care Provider, on the same terms, for a least ninety days following notice of termination.

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

Specialist means a Physician, Practitioner or urgent care center that does not otherwise meet the definition of a Primary Care Provider or Practitioner. This definition does not include naturopaths.

GENERAL DEFINITIONS

Allowed Amount means:

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

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

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

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

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

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

Claimant means a Participant or a Beneficiary.

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

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

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

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

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Claimant's health, or with respect to a pregnant Claimant, her health or the health of her unborn child, in serious jeopardy;

- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

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

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-Reviewed Medical Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:
  - Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
  - Standard Reference Compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

Family means a Participant and his or her Beneficiaries.

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

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

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

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

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

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

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

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose or treat an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider, and not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors. (If "Medically Necessary" or "Medical Necessity" is specifically defined in any benefit under the Medical Benefits section, such definition shall be applicable for purposes of that benefit instead of this definition.)

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

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.

Regence refers to Regence BlueShield.

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

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

Service Area means King County and the following zip codes within Snohomish County in the state of Washington: 98012, 98021, 98208, 98272, 98290, 98296.

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.

Your Prescription Medication Benefits Administered By CVS Caremark

Your prescription medication coverage is administered through CVS Caremark. Regence BlueShield assumes no liability for the accuracy of your prescription drug benefits information. Please visit CVS Caremark's website at visit **www.caremark.com** or contact CVS Caremark's Customer Service at 1 (844) 380-8838 if you have questions.

Prescription drug services for King County members are provided by CVS Caremark, a pharmacy benefit manager that isn't affiliated with Regence. CVS Caremark contracts with pharmacies that participate in its nationwide network. The network includes all major chain pharmacies and most independent pharmacies, as well as a mail-order service, which have agreed to dispense covered prescription drugs to plan members at a discounted cost and not to bill plan members for any amounts over the copays.

CVS Caremark issues a separate prescription card to King County members to use when filling prescriptions at network pharmacies or through the CVS Caremark mail-order service. If you don't show your prescription card, the network pharmacy cannot confirm that you're covered through CVS Caremark. In this case, you'll need to pay the pharmacy in full and submit a claim to CVS Caremark for reimbursement. Please contact CVS Caremark customer service at 1 (844) 380-8838 or visit **www.caremark.com** for more information.

You may receive up to a 30-day supply from a retail network pharmacy. You may receive a 30-day, 60-day or 90-day supply per prescription or refill through the mail-order service. If you use the mail-order service, you pay the 90-day copay even if your prescription is written for less than a 90-day supply. For a list of participating network pharmacies, contact CVS Caremark.

ACCESSING PHARMACY CARE

You may receive network benefits or out-of-network benefits, but the level of coverage depends on the pharmacy you use.

Retail Pharmacy Purchases

To fill a prescription at a network pharmacy and receive network benefits:

- you must choose an CVS Caremark network pharmacy;
- show your CVS Caremark prescription card to the network pharmacist each time you fill or refill a prescription (your Regence medical card isn't valid when you purchase prescription drugs); and
- pay the copay for each covered new prescription or refill. There are no claim forms to submit because the network pharmacy bills the plan directly.

For certain prescription drugs and quantities, your physician will need to obtain preauthorization from CVS Caremark.

If you fill a prescription at an out-of-network pharmacy, you must pay the cost of the prescription and submit a claim to CVS Caremark for reimbursement. CVS Caremark reimburses you at the rate it would pay a network pharmacy, less the appropriate copay. **Any amount in excess of this rate is your responsibility.**

Mail-Order Purchases

You may purchase maintenance drugs through the mail-order service. "Maintenance drugs" are drugs you must take on an ongoing basis. The first time you use the mail-order service, fill out the patient information questionnaire on the order form available from CVS Caremark. This form also includes options for payment. You need to complete this questionnaire only once.

Each time you order a new prescription, you can either:

- send the order form and prescription, together with your payment, directly to the address on the form; or
- have your physician fax the prescription directly from his/her office or call CVS Caremark directly.

Once you have submitted the order form, you may obtain refills through the CVS Caremark Website, mail in your refill slip or call CVS Caremark.

All prescriptions are processed promptly and usually arrive within 14 days. If you don't receive your medicine within 14 days or if you have questions, contact CVS Caremark customer service.

Your plan covers 30-day fills of medications you take regularly at any pharmacy in our network. After that, you can choose to have 90-day supplies of your long-term medications delivered by CVS Caremark Mail Service Pharmacy or pick them up at any CVS Pharmacy (including those inside Target stores) at the mail order copay.

If you use the mail-order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply. There's no out-of-network mail-order service.

	Network Pharmacy	Out-of-network Pharmacy	Limitations
Generic drugs	$5 copay / retail prescription $10 copay / mail-order prescription	$5 copay plus remaining balance after pharmacy is paid at network rate	Out-of-pocket limit: $1,500 per individual / $3,000 per family per year. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment. For specialty drugs, the first fill is allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy.
Preferred brand drugs	$25 copay / retail prescription $50 copay / mail-order prescription	$25 copay plus remaining balance after pharmacy is paid at network rate	
Non-preferred brand drugs	$75 copay / retail prescription $125 copay / mail-order prescription	$75 copay plus remaining balance after pharmacy is paid at network rate	
Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above.		

SPECIALTY PHARMACY/CVS CAREMARK

If you take specialty injectable/biotech prescription drugs, you may fill your specialty prescriptions at a local retail pharmacy one time only. For all subsequent prescriptions of your medication, you'll be directed to fill your prescriptions through the CVS Specialty Pharmacy. After your first retail fill, CVS Caremark will send you a letter that details how to have your prescription transferred to the specialty pharmacy. If you want to contact CVS Caremark to receive your supply of specialty medication(s), call CVS Caremark.

CVS Caremark is closed Sundays and holidays, including New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas.

A patient care coordinator will contact your doctor and work with you to schedule a delivery time for your medication.

Coverage While Traveling Outside the U.S.

If you will be traveling outside the United States, you can notify CVS Caremark in advance of your travel and obtain up to a three-month supply of your prescription drugs from a network pharmacy at the regular copay rate. CVS Caremark will allow you and your covered dependents to obtain an advance three-month supply of medications for foreign travel up to two times a year per person.

If you will be traveling abroad for longer than three months, be prepared to purchase your prescription drugs at the retail rate in those other countries after your supply runs out. When you return to the United States, you will need to submit a claim for reimbursement of prescription drug purchases you made in those other countries. Your purchase of prescription drugs in other countries will be treated as an out-of-

network expense and will be reimbursed at the out-of-network rate. For purposes of claim reimbursement, Puerto Rico, Guam and the U.S. Virgin Islands are not considered foreign countries, but cruise ships are.

For more information about filing a claim for prescription drugs purchased outside the U.S., contact CVS Caremark before you travel.

Coverage during a Natural Disaster

When a natural disaster occurs, prescriptions drugs may be lost or destroyed, and home delivery may not be feasible. Under certain circumstances resulting from a natural disaster, CVS Caremark may choose to allow members living in affected areas to obtain prescription drugs ahead of the regular refill schedule. For more information about obtaining prescriptions during a natural disaster, contact CVS Caremark.

FORMULARY

Your copay for a particular prescription is based on a list of drugs called a formulary, which sets the copay for that particular prescription based on its inclusion or exclusion in the formulary. For a copy of the formulary, including formulary alternatives, contact CVS Caremark.

PREAUTHORIZATION

CVS Caremark doesn't determine the maximum number of refills or period when a prescription is valid because these limitations are mandated by federal and state laws regulating pharmacy practices. To promote proper use of medications, preauthorization and quantity-level limits have been implemented for certain prescriptions under your King County pharmacy benefit.

You or your prescribing physician can find out if preauthorization is required by contacting CVS Caremark before you have a prescription filled. For you and your physician's convenience, CVS Caremark customer service assistance is available 24 hours a day, seven days a week at 1 (844) 380-8838. Otherwise, your pharmacist or the CVS Caremark mail-order service will advise you of the preauthorization procedures required to fill the prescription.

CVS Caremark routinely reviews prescribing guidelines to ensure that drugs are clinically appropriate, and may limit the quantities of certain drugs to ensure proper utilization. The list of drugs requiring preauthorization is subject to change.

To preauthorize a prescription, your prescribing physician or his/her representative must initiate the process with a phone call to CVS Caremark.

During the course of the review process, your eligibility will be confirmed and your prescription records checked to see if the prescription meets the established criteria.

Preauthorization requests are evaluated using criteria approved by King County. The request is then approved, denied or held for further information. If more information is required, CVS Caremark will notify the requestor. Once the information is provided by your physician, your request will be approved or denied.

If the request is approved, CVS Caremark will notify your physician and immediately update its database so you can fill the prescription.

If the request is denied, an CVS Caremark clinical pharmacist will verify that the denial is valid according to plan criteria. CVS Caremark will then notify:

- your physician verbally if the request was received by phone call; or
- you and your physician in writing if the request was received by mail.

When you receive a written denial, you may appeal that decision.

WHAT'S COVERED AND WHAT'S NOT

Covered Expenses

Your King County prescription benefit covers:

- contraceptives (including oral, injectable, vaginal, topical and implantable);
- DESI drugs;
- emergency allergic reaction kits;
- emergency contraceptives;
- erectile dysfunction drugs, if used to treat impotency or penile dysfunction and preauthorized;
- flu vaccinations, including High Dose Flu Vaccine and Flumax, performed at pharmacies contracted with CVS Caremark;
- glucagon emergency kit;
- growth hormones are covered for certain medical conditions and must be preauthorized whether you receive network or out-of-network care. If you receive this drug from your physician, he/she will bill CVS Caremark for the drug and its administration. If you obtain the drug from a retail pharmacy or mail-order service, CVS Caremark pays for the drug and for administration by your physician, if needed;
- immunizations outside of reform, for the purposes of travel, occupation or residency in a foreign country at regular plan cost shares:
  - Japanese encephalitis virus vaccine;
  - Yellow Fever vaccines;
  - Typhoid vaccines;
  - Cholera vaccine; and
  - Dengue vaccine (not approved by FDA yet).
- infertility medications;
- injectable prescription drugs purchased at a retail pharmacy or through mail-order as a specialty drug (for some, preauthorization may be required; some injectables may be covered under medical services for a patient at a hospital);
- insulin and diabetic supplies, including:
  - alcohol swabs;
  - blood glucose testing strips;
  - injection devices (such as Novopen);
  - insulin administered by pen/cartridge or other special injection devices;
  - insulin needles and syringes;
  - insulin/pre-drawn syringes;
  - ketone testing strips;
  - lancets;
  - lancet devices;
  - monitors; and
  - urine glucose testing strips;
- legend drugs;
- ostomy supplies;
- medically necessary vitamins;
- shingles (zoster) vaccination at age 55 and older, performed at pharmacies contracted with CVS Caremark;
- smoking cessation drugs, inhalers and nasal sprays requiring a prescription (claims for non-prescription nicotine patches, lozenges and gum are covered at 100% through Regence; and
- topical smoking cessation patches whether prescription or over-the-counter.

Expenses Not Covered

The following items are not covered by your King County prescription benefit:

- anorexiants/weight-loss medications;

- any over-the-counter medication unless otherwise noted;
- blood products;
- compound drugs of which at least one ingredient is not a covered prescription drug;
- cosmetic/hair loss medications;
- experimental medications that have not been approved by the FDA;
- therapeutic devices or appliances, including hypodermic needles, syringes (except those used for insulin and in the course of administering medical treatment), support garments and other non-medical substances regardless of intended use; and
- vitamins (except prenatal).

In addition to the exclusions or limits described in other sections of this guide, King County doesn't cover:

- charges that exceed the amounts CVS Caremark pays its network pharmacies;
- drugs for a covered child's maternity care;
- Viagra (unless preauthorized);
- non-approved drugs and substances (those the FDA hasn't approved for general use and has labeled "Caution—Limited by federal law to investigational use"); and
- treatment of sexual dysfunction regardless of cause, including, but not limited to devices, implants, surgical procedures, and medications.

MANAGING YOUR MEDICATIONS

Through a program called Medication Therapy Management Services, you may receive personal consultation on managing the interactions and potential complications of the multiple medications you're taking. Without additional cost to you, you may ask certified pharmacists to:

- review your entire list of medications, including prescription, herbal and over-the-counter medications, to make sure you're not taking medications that conflict with each other;
- answer your questions about correct dosage and frequency of dosage;
- answer your questions about risks and side effects from multiple prescriptions (certified pharmacists make one follow-up call to make sure you're not experiencing complications);
- find a less expensive medication covered under King County; and
- answer questions about over-the-counter medications.

FILING A CLAIM

When you go to a network pharmacy, there's no claim to file. However, if you fill a prescription at an out-of-network pharmacy, you're responsible for paying the pharmacy in full and submitting a claim to CVS Caremark, which will reimburse you at the negotiated rate within its network. To obtain a claim form, contact CVS Caremark. For the group number to use when filing a claim, see Contact Information.

When submitting a pharmacy claim, you need to include a completed claim form, together with the original prescription receipt, containing the following information:

- patient's name;
- NCPDP number (pharmacy's number) if listed on label;
- prescription number;
- date filled;
- dollar amount;
- quantity;
- days' supply; and
- NDC number (drug code).

After your claim is processed, you'll receive written notice describing the approval (amount submitted, amount covered/allowed and amount of reimbursement) or the reason for denial. Payment for covered prescriptions is made directly to you. Reimbursement typically takes about 14 days.

For prompt payment, submit all claims as soon as possible to:

CVS Caremark Attn: Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136

Generally, CVS Caremark will not pay a claim submitted more than 12 months after the date of service or the date expenses were incurred. If you can't meet the 12-month deadline because of circumstances beyond your control, such as being legally incapacitated, submit the claim to King County along with a written explanation of the circumstances. The county will determine whether your claim should be considered for payment.

CLAIMS REVIEW AND APPEALS PROCEDURES

Claims Denied for Reasons Other Than Eligibility

If you disagree with the decision on your claim for prescription drug coverage, you (or your authorized representative) will have 180 days to file a written appeal after your receipt of the notice of adverse decision. The decision on your appeal will be based on all comments, documents, records and other information you submit, even if they weren't submitted or considered during the initial claim decision.

Appeals of An Adverse Decision

Mail appeals of an adverse decision to:

CVS Caremark Attn: Prescription Claim Appeals
MC 109 PO Box 52084 Phoenix, AZ 85072-2084
Fax: 866-443-1172

You should include the reasons you believe the claim was improperly denied, and all additional facts and documents you consider relevant in support of your appeal. The following type of information is helpful when submitting your appeal so that it may be handled in a timely manner:

- employee's full name;
- patient's full name;
- your CVS Caremark ID Number (located on the front of your prescription card);
- the date(s) services were provided;
- your mailing address;
- your daytime phone number(s);
- your e-mail address (if you would like to provide it);
- relevant information regarding the nature of your appeal; and
- a copy of your Explanation of Benefits, if applicable.

A new decision-maker will review your denied claim - the appeal will not be conducted by the individual who denied the initial claim. The new decision-maker will not give deference to the original decision on your claim. The reviewer will make an independent decision about the claim. If your claim was denied on the basis of medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim.

For appeals of adverse decisions involving urgent care claims, the plan will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between CVS Caremark and you or health plan providers by telephone, fax or other available expeditious methods.

Notice of Decision on Appeal

After your appeal is reviewed by CVS Caremark, you'll receive a notice of decision on appeal within the time frames specified below. The time frames for providing a notice of decision on appeal generally begin when all necessary information has been received to perform the review. Notice of decision on appeal will be provided in writing. Urgent care decisions may be delivered by telephone, fax or other expeditious methods. The time frames for providing a notice of decision on appeal are as follows:

- urgent care appeals. As soon as possible considering the medical urgency, but no later than 72 hours after CVS Caremark receives your appeal and all information necessary to perform review; and

- claim denial appeals. Within a reasonable period of time appropriate to the medical circumstances, but no later than 10 business days after CVS Caremark receives your appeal and all information necessary to perform review.

If the appeal is denied, legal remedies may be pursued, but you or your representative must first exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years of the date of service on which the claim is based, or you forfeit your right to legal action.

DEFINITIONS

DESI drugs
"DESI (Drug Efficacy Study Implementation) drugs" are drugs that lack substantial evidence of effectiveness according to the FDA; but since they've been used and accepted for many years without significant safety problems, they continue to be used today.

Formulary
A formulary is a list of covered generic and brand-name prescription drugs.

Generic Medications
Generic medications contain the same active ingredient(s) as brand medications and are subject to the same Food and Drug Administration (FDA) standards of quality, strength and purity. Since generic medications may be available from many manufacturers, competition will lower the price of the medication, which saves you money.

Limitations
"Limitations" are restricting conditions such as age, time covered and waiting periods, which affect the level of benefits

Progressive medication management
"Progressive medication management" is a program for administering the use of medications so that the safest and most effective prescription drugs at the lowest cost are used, beginning with the use of generic drugs and progressing to the use of preferred and non-preferred drugs as medically necessary.

Specialty Medications
Specialty medications are medications that are used for the treatment of complex, rare and/or chronic conditions that may be expensive, require special handling, storage or administration and/or be available through limited or restricted distribution channels. You can find a list of specialty medications that are available through CVS Specialty Pharmacy at www.CVSSpecialty.com.

Specialty Pharmacy
A Specialty Pharmacy is a pharmacy that dispenses specialty medications and provides enhanced patient care and disease management for members utilizing specialty medications.

For more information contact the Claims Administrator at
1 (866) 240-9580

regence.com

Regence

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