# AWC HealthFirst® Plan

Association of
Washington Cities

Regence

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Effective January 1, 2016

# Introduction

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

## PLAN SPONSOR PAID BENEFITS

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

The following pages are the Booklet, the written description of the terms and benefits of coverage available under the Plan. This Booklet describes benefits effective January 1, 2016, 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.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Participant (employee) and Beneficiaries (family members of the employee) (except that in the Who Is Eligible, How To Enroll And When Coverage Begins, When Coverage Ends, COBRA Continuation, and Other Continuation Options sections, where applicable the terms "You" and "Your" mean the Participant only). The term "Claimant" means a Participant or a Beneficiary. The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

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

### NON-GRANDFATHERED

This coverage is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

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

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

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

**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.

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

Regence BlueShield also has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

# Using Your AWC HealthFirst Booklet

This Plan, administered by Regence, provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to Providers and innovative tools. With this health care coverage, You will discover more personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

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

Your Plan gives You broad access to Providers and allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under three choices called: "Category 1," "Category 2" and "Category 3."

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

For each benefit in this Booklet, the Provider You may choose and Your payment amount for each Category is indicated. Categories 1, 2 and 3 are also in the Definitions Section of this Booklet. You can go to **www.Regence.com** for further Provider network information.

**NOTE: If You use a Nonparticipating Provider (Category 3), You may not be able to assign Plan benefits to Your Nonparticipating Provider. Regence, as the Claims Administrator, in most instances will pay Plan benefits jointly to you and the Nonparticipating Provider, and You are responsible for paying the bills of your Nonparticipating Provider. You should discuss these payment arrangements with any Nonparticipating Provider you choose to use.**

## ADDITIONAL PARTICIPATION ADVANTAGES

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

powered by WebMD, to access an electronic version of this benefit booklet, your Health Questionnaire, and personalized health news.

You also have access to **www.Regence.com**, 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 www.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;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

## CONTACT INFORMATION

- **Learn more and receive answers about Your coverage.** Just call Customer Service: 1 (866) 240-9580 (TTY: 711) to talk with one of the Claims Administrator's Customer Service representatives or to request information in writing. Phone lines are open Monday-Friday 6 a.m. - 6 p.m.
- **Visit the Claims Administrator's Web site at: www.Regence.com**.
- **For assistance in a language other than English,** please call the Customer Service telephone number.
- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager 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. Call Case Management at 1 (866) 543-5765.
- **BlueCard® Program.** Learn how to have access to care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.
- **Medical Policy.** Regence medical policy and clinical criteria can be found at **http://blue.regence.com/trgmedpol**.

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# Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Copayments, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Medical Benefits Section to see exactly how they are applied and to which benefits they apply.

## CONTACT INFORMATION

Call Customer Service at 1 (866) 240-9580 (TTY: 711) or visit our Web site at **www.regence.com**.

## MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, dollar amount, or specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied against any specific Maximum Benefit that is expressed in this Booklet as a number of days, visits or services. Refer to the Medical Benefits Sections in this Booklet to determine if a Covered Service has a specific Maximum Benefit.

## OUT-OF-POCKET MAXIMUM

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

Claimants can meet the Out-of-Pocket Maximum by payments of Copayments and Coinsurance for all categories as specifically indicated in the Medical Benefits and Prescription Medication Benefits Sections. Any amounts You pay for non-Covered Services or 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 of this Plan.

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

## COPAYMENTS

Copayments are the fixed dollar amount that You must pay directly to the Provider for office visits, emergency room visits, inpatient facility admissions or Prescription Medication each time You receive a specified service or medication (as applicable). The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. The inpatient facility admission Copayment will be waived if You are readmitted within 30 days for the same condition or if You are transferred directly to another inpatient facility. Refer to the Medical Benefits Section to understand what Copayments You are responsible for.

Copayments applicable to Prescription Medications are located in the Prescription Medication Benefits Section of this Booklet.

## PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

Once You have satisfied any applicable Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any applicable specific 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 the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. However, a Preferred or Participating Provider will not charge You for any balances for Covered Services beyond Your Copayment

and/or Coinsurance amount if You choose Category 1 or Category 2. Nonparticipating Providers, however, may bill You for any balances over the Plan payment level in addition to any Copayment and/or Coinsurance amount if You choose Category 3. See the Definitions Section for descriptions of Providers.

## HOW CALENDAR YEAR BENEFITS RENEW

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

Some benefits of the Plan may have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year. Those exceptions include teaching doses of Self-Administrable Injectable Medication, hospice respite care, and nutritional counseling, and are further detailed in the benefits sections of this Booklet.

# Medical Benefits

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. There are no referrals required before You use any of the benefits of this coverage, including women's health care services. For Your ease in finding the information regarding benefits most important to You, the Plan has listed these benefits alphabetically, with the exception of the Preventive Care and Immunizations, Office Visits – Illness or Injury and Professional Services benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this plan. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Booklet for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service under the Plan.

### CALENDAR YEAR OUT-OF-POCKET MAXIMUM

**Per Claimant:** $1,100
**Per Family:** $2,200

### COPAYMENTS AND COINSURANCE

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

### CALENDAR YEAR DEDUCTIBLES

**Not applicable**

### PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other benefit in the Booklet, 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 list of services covered under this benefit, including but not limited to screening for obesity in adults and for adult patients with a body mass index (BMI) of 30 kg/m2 or higher, intensive, multicomponent behavioral interventions for weight management, please visit the Claims Administrator's Web site or contact Customer Service.

NOTE: Office visits that are billed as preventive and meet these criteria will be covered under this Preventive Care and Immunizations benefit. Conversely, Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury. Office visits that are not billed as preventive and do not meet these criteria will be covered under the Office Visit – Illness or Injury benefit.

### Preventive Care

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care (including contraceptives, HIV screening, HPV DNA testing, sterilization procedures, and certain patient

education and counseling services), routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation. See the Prescription Medication Benefits Section in this Booklet for a description of how to obtain Generic Medications and preventive medications and immunizations. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time).

### Immunizations - Adult

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers immunizations for adults according to, and as recommended by, the USPSTF and the CDC.

### Immunizations -Childhood

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges. |

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

### OFFICE VISITS – ILLNESS OR INJURY

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** After $10 Copayment per visit, the Plan pays 100% of the Allowed Amount. | **Payment:** After $10 Copayment per visit, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** After $10 Copayment per visit, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers office visits for treatment of Illness or Injury. The Copayment applies to visits in the office, home or Hospital outpatient department only. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (separate facility fees billed in conjunction with the office visit for example) are not considered an office visit under this benefit. For example, the Plan will pay for a surgical procedure performed in the office according to the Professional Services benefit.

## PROFESSIONAL SERVICES

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers services and supplies provided by a professional Provider subject to any Coinsurance and any specified limits as explained in the following paragraphs:

### Medical Services
The Plan covers professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include those to treat a congenital anomaly and foot care associated with diabetes.

### Professional Inpatient
The Plan covers professional inpatient visits for Illness or Injury. . If You are admitted as an inpatient to a Category 1 Hospital and the admitting Practitioner also is Category 1, then benefits for associated covered services provided during the admission by a Category 2 or 3 Hospital-based Practitioner (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) are eligible for coverage at the Category 1 level. In addition to usual cost-sharing, You may remain responsible for any amount by which billed charges exceed the Allowed Amount. For an inpatient admission directly from the emergency room and services were not covered at the Category 1 level, as described above, please contact Customer Service for an adjustment to Your claims.

### Radiology and Laboratory
The Plan covers services for treatment of Illness or Injury, including CAT scans, PET scans and MRIs. This includes, but is not limited to, prostate screenings and mammography services not covered under the Preventive Care and Immunizations benefit.

### Diagnostic Procedures
The Plan covers services for diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies, sleep studies and neurology/neuromuscular procedures.

### Surgical Services
The Plan covers surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist, including coverage of cochlear implants.

### Therapeutic Injections
The Plan covers therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medication Benefits Section of the Booklet. Teaching doses (by which a Provider educates the Claimant to self-inject) are covered for this list of Self-Administrable Injectable Medications up to a limit of three doses per medication per Claimant Lifetime. For a list of covered Self-Administrable Injectable Medications, call Customer Service or visit the Claims Administrator’s Web site.

## ACUPUNCTURE

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** 12 visits per Claimant per Calendar Year. | | |

For acupuncture to treat Substance Use Disorder, refer to the Substance Use Disorder Services benefit in this Medical Benefits Section.

## AMBULANCE SERVICES

| Category: All |
|---|
| **Provider: All** |
| **Payment:** The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

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

## APPROVED CLINICAL TRIALS

The Plan covers Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to the Coinsurance and/or Copayments and Maximum Benefits as specified in the Medical Benefits and Prescription Medications Benefits of this Booklet. Additional specified limits are as further defined. If a preferred Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these 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.

### Definitions

In addition to the definitions in the Definitions Section, 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;
- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis; or
- Services, supplies or accommodations for direct complications or consequences of the Approved Clinical Trial.

## BLOOD BANK

| **Category: All** |
|---|
| **Provider: All** |
| **Payment:** The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers the services and supplies of a blood bank, excluding storage costs.

## DENTAL HOSPITALIZATION

| **Category: 1** | **Category: 2** | **Category: 3** |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical center or a Hospital is necessary to safeguard Your health because treatment in a dental office would be neither safe or effective. Benefits are not available for services received in a dentist's office.

## DETOXIFICATION

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% of the Allowed Amount and You pay balance of billed charges. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. |

The Plan covers Medically Necessary detoxification services for alcoholism and drug abuse as an Emergency Medical Condition and does not require pre-authorization or pre-notification. You may choose to see a Category 1, Category 2 or Category 3 Provider. See the Definitions Section of this Booklet for a complete description of Category 1, Category 2 and Category 3 Providers.

## DIABETES SUPPLIES AND EQUIPMENT

The Plan covers supplies and equipment for the treatment of diabetes. Please refer to the Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medication benefits in this Booklet for coverage details of such covered supplies and equipment.

## DIABETIC EDUCATION

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers services and supplies for diabetic self-management training and education, including nutritional therapy if provided by Providers with expertise in diabetes.

## DIALYSIS

### Inpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

### Outpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers inpatient and outpatient services and supplies for dialysis. You may choose to see a Category 1, Category 2 or Category 3 Provider. See the Definitions Section of this Booklet for a complete description of Category 1, Category 2, and Category 3 Providers. You can also go to **www.Regence.com** for further Provider network information.

## DURABLE MEDICAL EQUIPMENT

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

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 and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item. The Plan also covers sales tax under this benefit for Durable Medical Equipment and mobility enhancing equipment, that is a Covered Service and when such equipment is not otherwise tax exempt.

## EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $75 Copayment per visit,* the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount.<br><br>*This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis. | **Facility Payment:** After $75 Copayment per visit,* the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount.<br><br>*This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis. | **Facility Payment:** After $75 Copayment per visit,* the Plan pays 90% and You pay balance of billed charges. Your 10% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.<br><br>*This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis. |

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, “stabilization” means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Claimant from a facility; and 2) in the case of a covered female Claimant, whom is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized.

If admitted to a Category 2 or 3 Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. In addition to usual cost-sharing, You may remain responsible for any amount by which billed charges exceed the Allowed Amount. For an inpatient admission directly from the emergency room and services were not covered at the Category 1 level, as described above, please contact Customer Service for an adjustment to Your claims. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

## FAMILY PLANNING

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount*. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>*Male sterilization will be paid at 100% of the Allowed Amount, not subject to the Deductible. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount*. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>*Male sterilization will be paid at 100% of the Allowed Amount, not subject to the Deductible. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy under this benefit.

For coverage of prescription contraceptives, please see the Prescription Medications benefit. You are not responsible for any applicable Copayment and/or Coinsurance when You fill prescriptions for FDA-

approved contraceptives prescribed by Your health care Provider. For a list of such medications, please visit the Web site or contact Customer Service.

For more information on preventive services for women, including HIV screening, HPV DNA testing, sterilization procedures, and certain patient education and counseling services, see the Preventive Care and Immunizations benefit of this Booklet or for a list of covered preventive services, please visit the Claims Administrator's Web site at: **www.Regence.com** or contact Customer Service at 1 (866) 240-9580.

## GENETIC TESTING

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** We pay 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

## HOME HEALTH CARE

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 90% of the Allowed Amount and You pay balance of billed charges. Your 10% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** 130 visits per Claimant per Calendar Year | | |

The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit in this Booklet.

## HOSPICE CARE

### Inpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% of the Allowed Amount and You pay balance of billed charges. Your 10% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** 14 inpatient or outpatient respite care days per Claimant Lifetime | | |

### Outpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** The Plan pays 90% and You pay balance of billed charges. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** 14 inpatient or outpatient respite care days per Claimant Lifetime | | |

The Plan covers hospice care 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: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Booklet.

## HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

### Inpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

### Outpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Surgical Center for Illness or Injury (including 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 as an inpatient to a Category 1 Hospital and the admitting Practitioner also is Category 1, then benefits for associated covered services provided during the admission by a Category 2 or 3 Hospital-based Practitioner (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) are eligible for coverage at the Category 1 level. In addition to usual cost-sharing, You may remain responsible for any amount by which billed charges exceed the Allowed Amount. For inpatient admissions directly from the emergency room and services were not covered at the Category 1 level, as described above, please contact Customer Service for an adjustment to Your claims. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

## KIDNEY DIALYSIS – OUTPATIENT

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Payment**: After Deductible, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment**: After Deductible, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** 42 treatments per Treatment Period per Claimant | | |

End Stage Renal Disease (ESRD) occurs when the kidneys no longer function properly, making dialysis necessary.

The Plan covers professional services, supplies, medications, labs and facility fees related to outpatient hemodialysis, peritoneal dialysis, and hemofiltration services 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 prior to Medicare coverage enrollment, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. See the Supplemental Kidney Dialysis - Outpatient benefit for coverage after the first 42 treatments in the first treatment period.

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 Kidney Dialysis – Outpatient

When Your Physician recommends kidney dialysis, You should first contact the Claims Administrator to begin Case Management and activate Your enrollment in the Supplemental Kidney Dialysis program described below. The enrollment in the Supplemental Kidney Dialysis program is voluntary and if You do not enroll in the program, You will not have access to the expanded benefits provided above.

A care management nurse may also contact You to discuss how to enroll in the Supplemental Kidney Dialysis program to reduce Your out-of-pocket costs and to discuss any concerns You may have about Your benefits and choices for Your dialysis and other ESRD-related services.

For any subsequent outpatient kidney dialysis beyond the first treatment period until Your 34th month after beginning dialysis, the Plan will provide additional supplemental coverage as described here if You have enrolled in this program. Supplemental dialysis benefits will not be retroactively covered if You choose to enroll after the first treatment period. This Supplemental Kidney Dialysis benefit covers 150% of the current Medicare reimbursement amount, not subject to any Deductible or Coinsurance, for the same or similar services as provided under the Kidney Dialysis benefit above.

In addition, a Claimant with ESRD is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the Claimant's ESRD 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.

Notwithstanding the above, in the event a Provider accepts Medicare assignment as payment in full, the eligible expenses are the lesser of the total amount of charges allowable by Medicare and the total eligible expenses allowable under this Plan, regardless of Your Medicare enrollment. This Supplemental Kidney Dialysis benefit applies to all Providers providing kidney dialysis related services.

If you would like to talk to a care management nurse or find out more about the program, please call 1 (888) 370-6159 (TTY users should dial 711). You may also call this number if you do not want to receive calls or letters regarding our Supplemental Dialysis Program.

## MATERNITY CARE

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), Medically Necessary supplies of home birth, complications of pregnancy, and related conditions for a female Participant or an enrolled female spouse or domestic partner of a Participant. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Booklet to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy for all female Claimants.

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

The Plan does not provide maternity benefits for Beneficiaries who are daughters of a Participant, except (1) benefits provided as Preventive Care; and (2) benefits for complications of pregnancy, including:

- fetal distress;
- gestational diabetes; and
- toxemia.

## MEDICAL FOODS (PKU)

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges. |

The Plan covers medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

## MENTAL HEALTH SERVICES

### Inpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

### Outpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers inpatient and outpatient Mental Health Services for treatment of Mental Health Conditions. Applied Behavioral Analysis (ABA) therapy services are covered for outpatient treatment of Autism Spectrum Disorders (ASD) when Claimants seek services from licensed Providers qualified to prescribe and perform ABA therapy services. A diagnosis of ASD/PDD must be made by an appropriate provider (neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or doctoral level psychologist) experienced in the diagnosis and treatment of autism. ABA therapy must be prescribed as appropriate for the patient and services must be Medically Necessary, meet Regence clinical criteria guidelines and providers must submit individualized treatment plans and progress evaluations. Specialized case management by Regence behavioral health services is highly recommended to support families through this process and can be reached by calling Regence Customer Service at 1 (866) 240-9580.

The AWC Trust has contracted with ComPsych, the AWC Employee Assistance Program Provider, to help manage the Mental Health Services benefit of this plan. If You wish, ComPsych will assist You in obtaining care by directing You to a mental health professional in Your area of residence or preferred location. Your counselor will identify the problem and outline solutions. A referral is recommended, although not required, through ComPsych. You may contact ComPsych seven days a week, 24 hours a day at 1 (800) 570-9315.

## Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health Services benefit:

Mental Health Conditions means mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under the Plan. 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 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

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Inpatient limit:** unlimited<br>**Outpatient limit:** 60 visits per Claimant per Calendar Year for all outpatient neurodevelopmental therapy services | | |

The Plan covers inpatient and outpatient neurodevelopmental therapy services. To be covered, such services must be to restore or improve function for a Claimant. Covered Services include only 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. See the Mental Health Services benefit for coverage of neurodevelopmental therapies, such as Applied Behavioral Analysis, that are considered Medically Necessary to treat a Mental Health Condition (including autism).

## NEWBORN CARE

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers services and supplies, 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 later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. For the purpose of this benefit, "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. For a newborn child admitted to the Hospital on an inpatient basis for Illness and Injury, please refer to the Hospital Care benefit.

## NUTRITIONAL COUNSELING

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** three visits per Claimant Lifetime (diabetic education and counseling is not subject to this limit). | | |

## ORTHOTIC DEVICES

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. Benefits under the Plan may be reduced for a less costly alternative item. The Plan does not cover off-the-shelf shoe inserts and orthopedic shoes.

## PROSTHETIC DEVICES

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

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

## REHABILITATION SERVICES

### Inpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Inpatient limit:** 15 days per Claimant per Calendar Year | | |

### Outpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** the Plan pays 90% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket. | **Payment:** the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Outpatient limit:** 99 visits per Claimant per Calendar Year | | |

The Plan covers inpatient and outpatient rehabilitation services (massage, physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Illness or Injury. Benefits will be provided for Maintenance Therapy in cases where significant deterioration in the Claimant's condition would result without the services. Outpatient

rehabilitation services are provided when rendered upon the written referral of a doctor of medicine or osteopathy. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

## SKILLED NURSING FACILITY (SNF) CARE

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% of the Allowed Amount and You pay balance of billed charges. Your 10% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** 90 inpatient days per Claimant per Calendar Year | | |

The Plan covers the inpatient services and supplies of a Skilled Nursing Facility 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. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

## SPINAL MANIPULATIONS

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |
| **Limit:** 15 spinal manipulations per Claimant per Calendar Year | | |

The Plan covers spinal manipulations performed by any Provider. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits in this Medical Benefits Section.

## SUBSTANCE USE DISORDER SERVICES

### Inpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

### Outpatient Services

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** The Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers Substance Use Disorder Services for treatment of Substance Use Disorder Conditions, including the following:

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

### Definitions

In addition to the definitions in the Definitions Section, 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 to be Medically Necessary).

Exclusively for the purpose of 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.

## TELEMEDICINE

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers telemedicine (audio and video communication) services between a distant-site Physician, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.

## TOBACCO USE CESSATION

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

Tobacco use cessation expenses not covered under the Preventive Care and Immunizations benefit are covered under this Tobacco Use Cessation benefit, as explained. For the purposes of this provision, a tobacco use cessation service means a service that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products. See the Preventive Care and Immunizations benefit and the Prescription Medication Benefits Section to see how tobacco use cessation Prescription Medications are covered.

## TRANSGENDER SERVICES

The Plan covers Medically Necessary services for gender identity disorder for adults and children. Covered services may include but are not limited to surgical services including facility and ancillary charges, prescription drugs, lab, x-ray and other non-surgical services and mental health treatment. These services are subject to the general plan provisions, limitations and exclusions of the Plan. Please refer to the Hospital, Professional Services, Office Visits, Prescription Medications, and Mental Health Services Benefits for specific coverage details.

**TRANSPLANTS**

| Category: 1 | Category: 2 | Category: 3 |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 100% of the Allowed Amount. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum. | **Facility Payment:** After $150 Copayment per inpatient admission, the Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.<br><br>**Professional Payment:** The Plan pays 70% of the Allowed Amount and You pay balance of billed charges. Your 30% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. |

The Plan covers transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions).

## Donor Organ Benefits

The Plan covers donor organ procurement costs 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 procurement costs that are determined to be paid under the Plan.

# Prescription Medication Benefits

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

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

### CALENDAR YEAR DEDUCTIBLES

**Not applicable**

### COPAYMENTS

You are responsible for paying the following Copayment amounts (at the time of purchase, if the Pharmacy submits the claim electronically). (See below for information on claims that are not submitted electronically and for information on maximum quantities.) However, there are no Copayments for preventive Prescription Medications (see section below).

### For Prescription Medications from a Pharmacy

| |
|---|
| • $4 for each Generic Medication. |
| • $15 for each Brand-Name Medication on the Formulary. |
| • $35 for each Brand-Name Medication not on the Formulary. |

### For Prescription Medications from a Mail-Order Supplier

| |
|---|
| • $8 for each Generic Medication. |
| • $30 for each Brand-Name Medication on the Formulary. |
| • $70 for each Brand-Name Medication not on the Formulary. |

### Maximum 34-Day or Greater Supply Limit

- **Injectable Medications.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy is a 34-day supply or from a Mail-Order Supplier is a 90-day supply.
- **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 90-day supply as indicated above.
- **Pharmacy and 34-Day Supply.** Except as specifically provided below, a 34-day supply is the largest allowable quantity of a Prescription Medication that You may purchase from a Pharmacy and for which a single claim may be submitted. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities.
- **Pharmacy and 90-Day Supply.** The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Copayment is based on each 34-day supply within that multiple-month supply. Oral contraceptives can be purchased for a single Copayment per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one Copayment per monthly cycle.

### Formulary Changes

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

For information please visit the Claims Administrator's Web site or contact Customer Service.

## COVERED PRESCRIPTION MEDICATIONS FOR TREATMENT OF ILLNESS OR INJURY

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

- Diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not glucometers, insulin pumps and their supplies), when obtained with a Prescription Order (glucometers, insulin pumps and their supplies are covered under the Durable Medical Equipment benefit). Call 1 (855) 306-2278 or visit OneTouch.orderpoints.com to have a free OneTouch meter shipped directly to your home or office. Use the code 701RERX01. Other brands of glucose meters also may be available depending on your prescription coverage;
- Brand-Name Medications and non-preventive Generic Medications for tobacco use cessation when obtained with a Prescription Order from a Participating Pharmacy;
- Prescription Medications;
- Foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States, except as may be provided under the Experimental/Investigational definition in the Definitions Section of this Booklet;
- Self-Administrable Cancer Chemotherapy Medication;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications);
- growth hormones (if preauthorized); and
- Specialty Medications. Specialty Medications are medications used for patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit the Claims Administrator's Web site or contact Customer Service.

## COVERED PRESCRIPTION MEDICATIONS FOR CERTAIN PREVENTIVE PRESCRIPTION MEDICATIONS

The Plan covers certain Prescription Medications as preventive care:

- Certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- all FDA-approved women's contraception methods as recommended by the HRSA when obtained with a Prescription Order; and
- immunizations for adults and children according to, and as recommended by, the CDC.

You are not responsible for any applicable Copayments when You fill prescriptions at a Participating Pharmacy, for specific strengths or quantities of medications that are specifically designated as preventive medications or for immunizations, as specified above. For example, FDA-approved contraceptives, prescribed to women by their health care Provider, are covered without cost-sharing. For a complete list of such medications, please visit the Claims Administrator's Web site or contact Customer Service. NOTE: The Copayment as listed in this Prescription Medication Benefits Section will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

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

### Self-Administrable Cancer Chemotherapy Medication
The Plan covers Self-Administrable Cancer Chemotherapy Medications according to this Prescription Medication Benefits Section. You are not responsible for any Copayment when You fill prescriptions for Self-Administrable Cancer Chemotherapy Medications.

## GENERAL PRESCRIPTION MEDICATION BENEFITS INFORMATION (NETWORK, SUBMISSION OF CLAIMS AND MAIL-ORDER)
A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. There are more than 1,200 Participating Pharmacies in the Claims Administrator's Washington State network from which to choose.

Your Plan identification card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Claimant through Regence BlueShield, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on the Claims Administrator's Web site or by contacting Customer Service. Medications dispensed to You while You are an inpatient in a Hospital, Skilled Nursing Facility, or other facility, that is not a Participating Pharmacy, will be provided under the applicable benefit.

### Claims Submitted Electronically
You must present Your Plan identification card at a Pharmacy for the claim to be submitted electronically. You must pay any required Copayment at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Nonparticipating Pharmacy will be paid directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as the applicable Copayment to the Nonparticipating Pharmacy at the time of purchase.

### Claims Not Submitted Electronically
When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to the Claims Administrator. You will be reimbursed based on the Covered Prescription Medication Expense, less the applicable Copayment that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. Payment will be sent directly to You.

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

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

To buy Prescription Medications through the mail, simply send all of the following items to a Mail-Order Supplier at the address shown on the prescription mail-order form available on the Claims Administrator's Web site or from the Plan Sponsor (which also includes refill instructions):

- a completed prescription mail-order form;
- any Copayment; and
- the original Prescription Order.

### Claimant's Right to Safe and Effective Pharmacy Services
State and federal laws establish standards to assure safe and effective Pharmacy services, and to guarantee Your right to know what medications are covered and what coverage limitations are under the Plan. If You would like more information about the medication coverage policies under the Plan, or if You have a question or a concern about Pharmacy benefits, please contact the Claims Administrator.

## PREAUTHORIZATION

Preauthorization may be required so that a determination that a Prescription Medication is Medically Necessary can be made before it is dispensed. The Claims Administrator publishes a list of those medications that currently require preauthorization. You can see the list on the Web site or call Customer Service. In addition, participating Providers, including Pharmacies, are notified which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

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

## LIMITATIONS

The following limitations apply to this Prescription Medication Benefits Section:

### Maximum Quantity Limit

For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service. The Plan does not cover any amount over the established maximum quantity, except if it is determined the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

### Refills

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

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

### Prescription Medications Dispensed by Excluded Pharmacies

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

## EXCLUSIONS

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

### Biological Sera, Blood or Blood Plasma

### Cosmetic Purposes
Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.

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

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

### Glucometers
Coverage for glucometers is provided under the Medical Benefits Section of the Plan.

### Insulin Pumps and Pump Administration Supplies
Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.

### Non-Self-Administrable Medications

### Nonprescription Medications
Medications that by law do not require a Prescription Order and which are not included in the definition of Prescription Medications, shown below, unless included on the Formulary.

### Prescription Medications for Treatment of Infertility

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

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

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

### Professional Charges for Administration of Any Medication

## DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medication Benefits Section:

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

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA.

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

Formulary means the Plan's list of selected Prescription Medications. The Plan utilizes the Formulary established by the Claims Administrator, who routinely reviews and updates the Formulary. It is available on the Claims Administrator's Web site or by calling the Claims Administrator's Customer Service. Medications are reviewed and selected for inclusion in the Formulary by an outside committee of providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by the Claims Administrator) as a Generic Medication. For the purpose of this definition, "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, the Claims Administrator will accept the Abbreviated New Drug Application (ANDA) submission to decide.

Mail-Order Supplier means a mail-order Pharmacy with which the Claims Administrator has contracted for mail-order services.

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

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

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included on the Claims Administrator's Formulary.

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

Self-Administrable Prescription Medications (also Self-Administrable Medications, or Self-Administrable Injectable Medication, or Self-Administrable Cancer Chemotherapy Medication) means, a Prescription Medication (including, for Self-Administrable Cancer Chemotherapy Medication, oral Prescription Medication used to kill or slow the growth of cancerous cells), determined by the Claims Administrator, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what are considered Self-Administrable Medications, the Claims Administrator refers to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability. Your status, such as Your ability to administer the medication, will not be considered when determining whether a medication is self-administrable.

Specialty Medications means medications used for patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit the Claims Administrator's Web site or contact Customer Service.

# Vision Benefits

In this section, You will learn how Your vision coverage works. The explanation includes information about Maximum Benefits, Covered Services and payment. Covered Services are those services required for the diagnosis of visual acuity and must be rendered by a Physician or optometrist practicing within the scope of his or her license.

All terms and conditions of the Booklet apply to this Vision Benefits Section, except as otherwise noted. Please see the Definitions Section in the back of this Booklet for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

**VISION EXAMINATION**

| **Category: 1** | **Category: 2** | **Category: 3** |
|---|---|---|
| **Provider: Preferred** | **Provider: Participating** | **Provider: Nonparticipating** |
| **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount. | **Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges. |
| **Limit:** one routine eye examination per Claimant per Calendar Year | | |

# Care Management and Wellness Programs

Under the Plan, You have access to the following AWC Trust-sponsored care management and wellness programs. The Plan Sponsor has chosen to provide these benefits to You. To the extent any part of these programs (for example, medications for smoking cessation) 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 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, please 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 coverage may be approved after case management evaluation and analysis. The Plan may cover alternative benefits through case management if the Plan determines, in its sole discretion, 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, You or Your legal representative and 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, please call 1 (866) 543-5765.

## SPECIAL BEGINNINGS

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

This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to their needs. Since Special Beginnings is most beneficial when a woman enrolls early in her pregnancy, call 1 (888) JOY-BABY (569-2229) or send an e-mail to OR_Special_Beginnings@regence.com right away to get started.

## REGENCE ADVICE24

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 Advice24 nurses have access to information about more than 5,500 health topics to ensure You receive the right care.

Call the Advice24 hotline any time-24 hours a day, seven days a week at 1 (800) 267-6729.

## QUIT FOR LIFE® TOBACCO CESSATION PROGRAM

Quit for Life helps people with tobacco addiction by offering a variety of resources, including personalized coaching, Web tools, educational materials and nicotine replacement therapy. This program offers a free personalized quit plan and has been proven to help individuals quit eight times more successfully than trying to quit without support.

To learn more, call 1 (866) QUIT-4-LIFE (784-8454) between 5 a.m. and 12 midnight Pacific time or visit quitnow.net/awc.

## HEALTH CENTRAL

Go to awctrust.org for your personal, secure health and benefits website. Here you'll find access to benefits information, health record, behavior change tools, articles and videos on health topics A-Z. You can also access your Health Assessment and personalized Health Coaching. For employees, spouses and domestic partners.

## HEALTH QUESTIONNAIRE (HQ)

A confidential assessment of your health status and health risks. Based on the answers you provide, the HQ instantly reveals a plan to improve your health. You will receive a financial reward for completing HQ each year. Log in to Health Central at awctrust.org to find HQ. For employees, spouses and domestic partners.

## HEALTH COACHING

Working with your health coach makes improving your health easier. Your health coach offers personalized guidance and encouragement to help you find your motivation and reach your health goals. To schedule your confidential coaching visit awctrust.org or call 1 (888) 321-1534. For employees, spouses and domestic partners.

## WEIGHT MANAGEMENT COACHING

An enhanced health coaching option for those with significant weight management goals. Weight Management Coaching offers one-on-one support by health experts to help you lose weight and keep it off. It includes a professionally monitored diet and personalized exercise planning. For employees, spouses and domestic partners.

## HEALTH SCREENINGS

Do you know your numbers? Check your cholesterol, triglycerides, blood pressure and more. Discuss results immediately with an onsite health coach. Health screenings are offered every other year at the worksite to employees, spouses and domestic partners.

## WELLNESS NEWSLETTER

The Wellness Newsletter offers wellness articles, stories, tips, quotes, recipes and entertaining cartoons. It is delivered monthly to your home.

# General Exclusions

The following are the general exclusions from coverage under the Plan. 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**.

### Assisted Reproductive Technologies

The Plan does not cover any assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated drugs, testing or supplies, regardless of underlying condition or circumstance.

### Conditions Caused By Active Participation In a War or Insurrection

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

### Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

### Cosmetic Services and Supplies

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 in the Absence of Illness

The Plan does not cover counseling in the absence of Illness. Examples of non-Covered Services: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program (EAP) services; wilderness programs; premarital or marital counseling; and family counseling when the identified patient is not a child or an adolescent with a covered diagnosis and family counseling is not part of the treatment.

### Custodial Care

Non-skilled care and helping with activities of daily living.

### Dental Services

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

### Expenses Before Coverage Begins or After Coverage Ends

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

### Fees, Taxes, Interest

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

### 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 medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the Service Area are not covered under the Plan (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

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

### Hearing Care
The Plan does not cover hearing care, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, non-cochlear hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them.

### Infertility Treatment
Treatment of infertility, including but not limited to fertility drugs and medications, except to the extent Covered Services are required to diagnose such condition.

### 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 of this Booklet.

### Mental Health Treatment For Certain Conditions
The Plan does not cover treatment of paraphilias or paraphilic disorders (except gender identity disorder in children or gender identity disorder in adolescents or adults). Additionally, the Plan does not cover any V code diagnoses, except for Medically Necessary treatment for children ages 5 and under for parent child problems, neglect or abuse, or bereavement. "V code" means codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the DSM, that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This includes, but is not limited to, such issues as occupational or academic problems.

### 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 direct patient 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 Telemedicine benefit.

### Obesity or Weight Reduction/Control
The Plan does not cover medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions, except to the extent Covered Services are required as part of the USPSTF, HRSA, or CDC requirements.

### Orthognathic Surgery
Services and supplies for orthognathic surgery not required due to 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 Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes are not covered.

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

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

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

### Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Claimant's **voluntary participation in** a riot, 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

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

- diet and weight monitoring services;
- childbirth-related classes including infant care; and
- instruction programs including those to learn how to stop smoking and programs 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. For purposes of this provision, "immediate family" means:

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

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

### Sexual Dysfunction
Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medications.

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

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

### Travel and Transportation Expenses
Travel and transportation expenses when the purpose of the transportation is for personal or convenience purposes.

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

### Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Illness or Injury, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under this coverage. The Plan does not cover services and supplies received for work-related Illnesses or Injuries even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Claimant is exempt from state or federal workers' compensation law.

# Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan.

## PREAUTHORIZATION

Preauthorization refers to the process by which the Claims Administrator determines that a proposed service or supply is Medically Necessary and provide approval for it before it is rendered.

Preauthorization is performed to ensure that the services You receive are aligned with evidence based criteria and to determine whether the requested service meets the Claim Administrator's Medical Necessity criteria. Preauthorization also ensures that services or supplies You receive are safe, effective, and appropriate, with the goal of helping You obtain the most out of Your health plan benefits and receiving the right care, at the right time, and in the right place.

Contracted Providers may be required to obtain preauthorization from the Claims Administrator in advance for certain services provided to You. Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator in advance for services. You, however, may be liable for costs if You elect to seek services and those services are not considered Medically Necessary and/or not covered under this Plan. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to the services being rendered.

A comprehensive list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Claims Administrator's Web site at: **https://www.regence.com/web/regence_provider/pre-authorization** or by calling 1 (866) 240-9580.

Preauthorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's Web site listed above.

### Timeframe for Response

You will be notified in writing within 15 calendar days of the Claims Administrator's receipt of the preauthorization request whether the request has been approved, denied, or if more information is needed to make a determination.

### When More Information is Needed to Make a Determination

Additional information requested by the Claims Administrator must be received within 45 calendar days of the date on the letter requesting information. The Claims Administrator will notify You in writing of the determination within 15 calendar days of receipt of additional information or within 15 calendar days of the end of the 45 day period if no additional information is received.

If You or Your Physician believes that waiting for a determination under the standard time frame could place Your life, health, or ability to regain maximum function in serious jeopardy, Your Physician should notify the Claims Administrator by phone or fax as a shorter time frame for response may apply.

Preauthorization does not guarantee payment. The Claim Administrator's reimbursement policies may affect how claims are reimbursed, and payment of benefits is subject to all Plan provisions, including eligibility for benefits at the time of services.

## PLAN IDENTIFICATION CARD

When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

It is important to keep Your Plan identification card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling the Claims Administrator's Customer Service department. You can also view or print an image of Your Plan

identification card by visiting the Claims Administrator's Web site on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

## SUBMISSION OF CLAIMS AND REIMBURSEMENT

The Claims Administrator's decision to pay the Claimant, Provider or Provider and Claimant jointly is made pursuant to any legal requirements. Payments are primarily issued as joint payee checks to both the Claimant and the Provider for Category 3 Provider claims. The exceptions would be if a Claimant submits sufficient documentation that they have "paid the Provider in-full." In those circumstances, the Claims Administrator may issue payment to the Claimant only.

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

### Calendar Year

The Out-of-Pocket Maximum provision is calculated on a Calendar Year basis.

### Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished 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, however, appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

### Freedom of Choice of Provider

Nothing contained in this Booklet is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

### Category 1 and Category 2 Claims

You must present Your Plan identification card when obtaining Covered Services from a preferred or participating Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.

### Category 1 and Category 2 Reimbursement

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

### Category 3 Claims

In order for Covered Services to be paid, You or the nonparticipating Provider must first send the Claims Administrator a claim. Be sure the claim is complete and includes the following information:

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

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.

### Category 3 Reimbursement

In most cases, payment is issued as a joint payee check to both the Claimant and the Provider.

Nonparticipating Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the

nonparticipating Provider and the Allowed Amount in addition to any amount You must pay due to Copayment and/or Coinsurance. For nonparticipating Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

**NOTE: If You use a Nonparticipating Provider (Category 3), You may not be able to assign Plan benefits to Your Nonparticipating Provider. Regence, as the Claims Administrator, in most instances will pay Plan benefits jointly to you and the Nonparticipating Provider, and You are responsible for paying the bills of your Nonparticipating Provider. You should discuss these payment arrangements with any Nonparticipating Provider you choose to use.**

### Ambulance Claims

When You or Your Provider forwards a claim for ambulance services to the Claims Administrator, it must show where the patient was picked up and 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 on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim 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 referred to generally as “Inter-Plan Programs.” Whenever You obtain health care services outside of the Claims Administrator’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator's service area, You will obtain care from health care Providers that have a contractual agreement (i.e., are “participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, You may obtain care from nonparticipating Providers. The Claims Administrator's payment practices in both instances are described below.

### BlueCard Program

Under the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You access Covered Services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or

- The negotiated price that the Host Blue makes available to the Claims Administrator.

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

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

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate Your liability for any Covered Services according to applicable law.

### Negotiated National Account Arrangements

As an alternative to the BlueCard Program, Your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to the Claims Administrator by the Host Blue.

### Nonparticipating Providers Outside the Claims Administrator's Service Area

- Member Liability Calculation. When Covered Services are provided outside of the Claims Administrator's service area by nonparticipating Providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.
- Exceptions. In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator will pay for services rendered by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

## BLUECARD WORLDWIDE®

BlueCard Worldwide coverage is also accessible to You. With BlueCard Worldwide, You have access to inpatient and outpatient Hospital care and Physician services when You're traveling or living outside the United States as well as medical assistance and claims support services.

When You need health care outside of the United States or its territories, follow these simple steps:

- Always carry Your current Plan identification card.
- If You need emergency medical care outside the United States, go to the nearest Hospital.
- If You are admitted, call the BlueCard Worldwide Service Center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177.
- For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide Hospital or make an appointment with a Physician. BlueCard Worldwide Service Center staff are available to assist You 24 hours a day, 7 days a week.

- You will only be responsible for out-of-pocket expenses such as any applicable Copayment, Coinsurance and non-covered services for Your inpatient care. For outpatient, Hospital care or Physician services, You will be responsible for paying the Hospital or Physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide Service Center for reimbursement of Covered Services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide program at **www.bcbs.com**.

## 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.

## 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 TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator and by the AWC Trust. This information will be used in accordance with the Claims Administrator's Notice of Privacy Practices and the AWC Trust's Notice of Privacy Practices. You can request a copy of the Claim Administrator's Notice simply by calling the Claims Administrator's Customer Service department or by visiting the Web site. The AWC Trust's Notice of Privacy Practices is available by calling 1-800-562-8981 or by visiting
**http://www.awcnet.org/Portals/0/Documents/Trust/HIPAAPrivacyPolicyAWCTrust.pdf**.

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

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

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

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

- medical records.

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

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

## LIMITATIONS ON LIABILITY

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

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

## RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Coverage under the Plan will not be provided for any medical (or dental and vision, if applicable) or Prescription Medication expenses You incur for treatment of an Illness or Injury if the costs associated with the Illness or Injury may be recoverable from any of the following:

- a third party;
- workers' compensation; or
- any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage.

### Advancement of Benefits

If You have a potential right of recovery for Illnesses or Injuries from a third party who may have legal responsibility or from any other source, benefits may be advanced pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Illness or Injury for which benefits under the Plan have been provided.
- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- The Plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Claimant and/or any third party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
    - the third party or third party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Plan.
- Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.

- You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:

  - the filing of a lawsuit;
  - the making of a claim against any third party;
  - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - intent of a third party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Illness or Injury that gives rise to the Plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Illness or Injury giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.
- Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

### Motor Vehicle Coverage

If You are involved in a motor vehicle accident, 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, this right of reimbursement and subrogation provision still applies.

### Workers' Compensation

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

- You must notify the Claims Administrator 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 claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

### Fees and Expenses

Neither the Plan nor the Claims Administrator is liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that a proportional share of attorney's fees and costs be paid at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the Plan. The Claims Administrator has discretion whether to grant such requests.

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

## COORDINATION OF BENEFITS
The Coordination of Benefits (COB) 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.

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

An 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 COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB 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 COB 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 COB 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 COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

When This Plan is primary, it determines payment for its benefits first before those of any Other Plan without considering any Other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals not less than the same Allowable Expense that this Plan would have paid if it were the Primary Plan. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for You. This reserve

must be used to pay any expenses during that Calendar Year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its Maximum Benefit plus any accrued savings.

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.

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 benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next Calendar Year;
  - 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 by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim cannot be less than the same Allowable Expense as the Secondary Plan would have paid if it was the Primary Plan. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

### Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB 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.

## 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 (866) 240-9580.

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. Please 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 health care 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.

### Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel of Claims Administrator employees who were not involved in, or subordinate to anyone involved in, 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.

## EXPEDITED APPEALS

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

- the application of regular Appeal timeframes 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.

### Panel-Level (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 a panel of 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 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.

There is no voluntary Appeal to the AWC Board of Trustees of the Panel-Level Appeal decision or the IRO Appeal decision on expedited Appeals.

## INFORMATION

If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator's Customer Service department at 1 (866) 240-9580 or You can write to the Claims Administrator's Customer Service department 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 under the Plan that is not considered Pre-Service.

Pre-Service means any claim for benefits under the Plan 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 purpose of the Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purposes of 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.

# Who Is Eligible, How to Enroll and When Coverage Begins

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

## INITIAL ELIGIBILITY, WHEN COVERAGE BEGINS

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

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

### Employees

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

### Dependents

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

- The person to whom You are legally married (spouse).
- Your registered domestic partner and if specifically included as eligible by Your employer, Your non-state registered domestic partner for whom an accurate and complete affidavit of qualifying domestic partnership has been submitted. Contact the AWC Trust for questions about whether Your non-state registered domestic partner is eligible for the Plan.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
  - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
  - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
  - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or mental or physical disability that began before his or her 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's incapacity acceptable to the Plan, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
  - he or she is a Beneficiary immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form for children age 26 or older is available by visiting their Web site or by calling Customer Service department. The Claims Administrator may request

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

## SPECIAL ENROLLMENT

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

### New Dependents

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

NOTE: The regular benefits of the Plan will be provided for a newborn child of a Participant and/or a Beneficiary who is the spouse of domestic partner of the Participant for up to 21 days following birth. There is no such coverage for newborn children of dependent children. Such benefits will not be subject to enrollment requirements for a newborn as specified here, or the payment of a separate charge for coverage of the child. Coverage, however, is subject to all provisions, limitations and exclusions of the Plan. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn.

### Loss of Other Coverage

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

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

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

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

### Qualification for Premium Assistance

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

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

Coverage will be effective on the first of the calendar month following the date We receive Your enrollment application.

## 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 (and, in the case of a non-registered domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

## DOCUMENTATION OF ELIGIBILITY

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

# When Coverage Ends

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

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

## MEMBER EMPLOYER TERMINATION

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

## WHAT HAPPENS WHEN PARTICIPANTS ARE NO LONGER ELIGIBLE

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

## TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

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

## NONPAYMENT

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

## FAMILY AND MEDICAL LEAVE

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

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

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

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

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern.

## PAID LEAVE OF ABSENCE

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

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

## WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

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

### Divorce or Annulment

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

### If You Die

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

### Termination of Domestic Partnership

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

### Loss of Dependent Status

- For a child who is no longer an eligible dependent due to reaching age 26, eligibility ends on the last day of the month in which the child’s 26th birthday occurs.
- For a child who is no longer eligible due to disruption of Placement for Adoption before legal adoption and who is removed from placement, eligibility ends on the last day of the month in which the child is removed from Placement for Adoption.
- For a child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the month in which the child is no longer a dependent.

## OTHER CAUSES OF TERMINATION

Claimants may be terminated for any of the following reasons.

### Fraudulent Use of Benefits

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

### Fraud or Misrepresentation in Application

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

## CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about certificates relating to period(s) of creditable coverage under the Plan should be directed to the Plan Sponsor, or to the Claims Administrator at P.O. Box 2998, Tacoma, WA 98401-2998.

# COBRA Continuation of Coverage

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

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

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

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

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

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

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

### Duration of COBRA Coverage

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

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

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

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

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

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

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

## Special considerations in deciding whether to elect COBRA

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

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

## How to apply and pay for COBRA

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

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

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

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

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

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

## Cost of COBRA

Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation coverage, plus an administration fee, even if the Member Employer contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent.

## COBRA Continuation Coverage and Retiree Coverage from the AWC Trust

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

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

## Address Changes

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

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

### COBRA Notice Procedures

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

Mail to:

AWC Employee Benefit Trust
c/o Northwest Administrators
P.O. Box 84303
Seattle, WA 98124

Fax to:

AWC Employee Benefit Trust
c/o Northwest Administrators
(206-926-2699)

Hand-deliver to:

AWC Employee Benefit Trust
1076 Franklin Street SE
Olympia, WA 98501

OR

AWC Employee Benefit Trust
c/o Northwest Administrators
2323 Eastlake Avenue East
Seattle, WA 98102

If mailed, the notice must be postmarked no later than the last day of the required notice period. In addition to the information required by the Plan for the notice, all notices must state:

- The name of the Plan,
- The name and address of the employee or former employee,
- The name(s) and address (es) of the qualified beneficiary (ies), and
- The qualifying event and the date it happened.

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

# General Provisions

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

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

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

### 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.

### NOTICES
Any notice to Claimants required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant will be addressed to the Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor 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: Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

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

### REPRESENTATIONS ARE NOT WARRANTIES
In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or

reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

## 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 Booklet; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

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

# Definitions

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

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

Allowed Amount means:

- For preferred and participating Providers (see definitions of "Category 1" and "Category 2" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For nonparticipating Providers (see definition of "Category 3" below) who are not accessed through the BlueCard Program, 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 for some services, as determined by the Claims Administrator or as otherwise required by law.
- For nonparticipating Providers (see definition of "Category 3" below) accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider.

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, please 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 for the purpose of providing 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 for this coverage. The Booklet is part of the Agreement between the Plan Sponsor and the Claims Administrator.

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

Category 1 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract and an effective preferred addendum or agreement with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a preferred Provider to provide services and supplies to Claimants in accordance with the provisions of this coverage.

Category 1 also means Providers outside the area that the Claims Administrator or one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to Claimants in accordance with the provisions of this coverage.

Category 1 reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Copayment and/or Coinsurance for Covered Services.

Category 2 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a participating Provider as well as Providers outside the area that or one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Participating Network") to provide services and supplies to Claimants in accordance with the provisions of this coverage. Category 2 reimbursement is generally a lower payment level than Category 1, but You will not be charged for balances beyond any Copayment and/or Coinsurance for Covered Services.

Category 3 means the benefit reimbursement level for services that are received from a Provider who does not have an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates to provide services and supplies to Claimants. Category 3 reimbursement is generally the lowest payment level of all categories, and You may be billed for balances beyond any Copayment and/or Coinsurance for Covered Services.

Claimant means a Participant or a Beneficiary.

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

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

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

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

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.

Essential Benefits are determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include at least the following general categories and the items and services covered within the categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

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.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Upon receipt of a fully documented claim or request for preauthorization related to a possible Experimental or Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Please contact the Claims Administrator by calling the Claims Administrator's Customer Service department at 1 (866) 240-9580 or by visiting the Claims Administrator's Web site at **www.Regence.com** for details on the information needed to satisfy the fully documented claim or request requirement. You may also have the right to an Expedited Appeal. Refer to the Appeal Process Section for additional information on the Appeal process.

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.

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

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

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

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

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

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

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

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

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

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, 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 his or her respective licenses.

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

Regence refers to Regence BlueShield.

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

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

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

Regence BlueShield
1800 Ninth Avenue
Seattle, WA 98101