



AWC HealthFirst® 250 Plan



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1-800-541-8981 (TTY: 711)

Customer Service for all other plans

1-888-344-6347 (TTY: 711)

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Medicare Customer Service

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

1-866-749-0355, (TTY: 711)

Fax: 1-888-309-8784

medicareappeals@regence.com

Customer Service for all other plans

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regence.com

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

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

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

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

PLAN SPONSOR PAID BENEFITS

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

The following pages are the Booklet, the written description of the terms and benefits of coverage available under the Plan. This Booklet is effective January 1, 2019, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueShield and makes it void.

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

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

Using Your AWC HealthFirst 250 Booklet

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

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

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

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

ADDITIONAL ADVANTAGES OF PARTICIPATION

Your Plan offers You access to valuable services. These include discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. Register at awctrust.org for Your **Health Central** account to access an electronic version of this benefit booklet, Your Health Assessment, and personalized health news.

You also have access to the Claims Administrator's Web site, an interactive environment that can help You navigate Your way through health care decisions. These additional valuable services are a complement to the group health plan, but are not insurance.

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:
 - view recent claims, benefits and coverage;
 - find a contracting Provider;
 - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
 - discover discounts on select items and services*;
 - identify Participating Pharmacies;
 - find alternatives to expensive medicines;
 - learn about prescriptions for various illnesses; and
 - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

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

ENHANCED SERVICES, SUPPORT, AND ACCESS

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

- **Enhanced convenience and options for access to medical care.** These may include additional resources for You to receive covered medical care, such as enhanced virtual care options that are integrated with Your telehealth and telemedicine, durable medical equipment, preventive, behavioral health, and/or other benefits. You may also be offered increased ease in accessing non-Covered Services, such as cosmetic services or in integrating care for complex and multi-Provider conditions.
- **Healthcare and vitality assistance tools.** You may have tools that enable You to make and track medical appointments; manage health care expenses; receive support in caring for others; remember to timely refill prescriptions and perform regular self-care; track weight, food, and exercise statistics; receive coaching; and more.
- **Non-medical lifestyle enhancements.** These may include access or assistance with non-medical services, such as resilience, mindfulness, yoga or stress reduction programs, and pet wellness and insurances services.

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

CONTACT INFORMATION

- **Call Customer Service:** 1 (800) 752-9985 (TTY: 711) if You have questions, would like to learn more about Your Plan, or would like to request written or electronic information. Phone lines are open Monday-Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.
- **Visit the Claims Administrator's Web site: regence.com.**
- **For assistance in a language other than English,** call the Customer Service telephone number.
- **Call Case Management:** 1 (866) 543-5765 to request that a case manager be assigned to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers.
- **BlueCard® Program.** Call Customer Service to learn how to access care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.
- **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 Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum.

This section defines cost-sharing elements, but You will need to refer to the benefit section(s) to see exactly how they are applied.

CONTACT INFORMATION

Call Customer Service at 1 (800) 752-9985 (TTY: 711) or visit the Web site at regence.com.

MAXIMUM BENEFITS

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

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

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

OUT-OF-POCKET MAXIMUM

You can meet the Out-of-Pocket Maximum by Your payments of Deductibles, Copayments and Coinsurance.

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 Plan's 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.

Cost sharing savings that result from Your use of a drug manufacturer coupon for Prescription Medications will be applied to Your Out-of-Pocket Maximum. However, if application of any drug manufacturer coupon savings is found to have caused You to exceed Your Out-of-Pocket Maximum, You will not be refunded the coupon amount that exceeds Your Out-of-Pocket Maximum.

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

COPAYMENTS

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

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

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

Once You have satisfied any applicable Deductible and Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any 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 either the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the 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 Deductible, 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 Deductible, Copayment and/or Coinsurance amount if You choose Category 3. See the Definitions section for descriptions of Providers.

DEDUCTIBLES

The Plan will begin to pay benefits for Covered Services in any Calendar Year only after a Claimant satisfies the Calendar Year Deductible. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year.

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

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

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

HOW CALENDAR YEAR BENEFITS RENEW

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

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

Medical Benefits

This section explains how Your coverage pays for Covered Services. All covered benefits are listed under each benefit table. Most benefits are listed alphabetically.

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

Some services may require a prescription or preauthorization. Contracted Providers may be required to seek preauthorization from the Claims Administrator before providing some services for You. You will not be penalized if the Contracted Provider does not obtain preauthorization in advance from the Claims Administrator and the service is later determined to be not covered. Non-Contracted Providers are not required to obtain preauthorization from the Claims Administrator prior to providing services. You may be liable for the cost of services provided by a Non-Contracted Provider if those services are not Covered Services nor Medically Necessary. You may request that a Non-Contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services. A comprehensive list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Web site at: https://www.regence.com/web/regence_provider/pre-authorization or by calling 1 (800) 752-9985.

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

In some cases, benefits or coverage may be limited to a less costly and Medically Necessary alternative item. Reimbursement may be available for new medical supplies, equipment, and devices You purchase from a Provider or from an approved commercial seller, even though that seller is not a Provider. New medical supplies, equipment, and devices, such as a breast pump or wheelchair, purchased through an approved commercial seller are covered at the Category 1 level, with reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market for that item. To learn more about how to access an approved commercial seller and reimbursable new retail medical supplies, equipment, and devices, visit the Web site or contact Customer Service.

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Per Claimant: \$3,000

Per Family: \$6,000

COPAYMENTS AND COINSURANCE

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

CALENDAR YEAR DEDUCTIBLES

Per Claimant: \$250

Per Family: \$750

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new

or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a complete list of services covered under this benefit, including information about how to access an approved commercial seller, obtaining a new breast pump and instructions for obtaining reimbursement for a breast pump purchased from an approved commercial seller, retailer, or other entity that is not a Provider, visit the Web site or contact Customer Service.

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

NOTE: Services 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. For example, 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: You pay 0% of the Allowed Amount.	Payment: You pay 0% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

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

- routine physical examinations, well-baby care, women's care, and health screenings including screening for obesity in adults and for adult patients with a body mass index (BMI) of 30 kg/m² or higher;
- intensive multicomponent behavioral interventions for weight management;
- Provider counseling and prescribed medications for tobacco use cessation;
- depression screening for all adults, including screening for maternal depression;
- one non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from a Provider (including a Durable Medical Equipment supplier) or a comparable breast pump obtained from an approved commercial seller, even though that seller is not a Provider; and
- Food and Drug Administration (FDA) approved contraceptive drugs, devices and other products such as implants (including the insertion and removal of those devices and implants) and sterilization methods including, but not limited to, condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants, surgical sterilization, and vasectomy.

Immunizations - Adult

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: You pay 0% of the Allowed Amount.	Payment: You pay 0% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

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

Immunizations - Childhood

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: You pay 0% of the Allowed Amount.	Payment: You pay 0% of the Allowed Amount.	Payment: You pay 0% of the Allowed Amount and You pay any balance of billed charges.

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

Immunizations - Travel

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: You pay 0% of the Allowed Amount.	Payment: You pay 0% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.

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

OFFICE VISITS – ILLNESS OR INJURY

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

Office visits for treatment of Illness or Injury are covered. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit are not considered an office visit.

PROFESSIONAL SERVICES

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

Services and supplies are covered as explained in the following paragraphs:

Diagnostic Procedures

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

Medical Services and Supplies

Professional services, second opinions and supplies are covered, including the services of a Provider whose opinion or advice is requested by the attending Provider. Services and supplies also include those to treat a congenital anomaly and foot care associated with diabetes.

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

Professional Inpatient

Professional inpatient visits for Illness or Injury are covered. If You are admitted as an inpatient to 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. If You are admitted as an inpatient directly from the emergency room and services were not covered at the Category 1 level, as described above, contact Customer Service for an adjustment to Your claims.

Radiology and Laboratory

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

Surgical Services

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

Therapeutic Injections

Therapeutic injections and related supplies are covered when given in a professional Provider's office.

ACUPUNCTURE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 10% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: 12 visits per Claimant per Calendar Year.		

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

AMBULANCE SERVICES

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

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

AMBULATORY SURGICAL CENTER

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

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

APPROVED CLINICAL TRIALS

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

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

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

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

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

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

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

BLOOD BANK

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

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

DENTAL HOSPITALIZATION

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

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

DETOXIFICATION

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

Medically Necessary detoxification is covered.

DIABETIC EDUCATION

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

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

DIALYSIS – INPATIENT

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

Inpatient services and supplies for dialysis are covered.

DIALYSIS – OUTPATIENT**Initial Outpatient Treatment Period**

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 10% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay balance of billed charges.
Outpatient limit: 42 treatments per Claimant		

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

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

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

Supplemental Outpatient Treatment Period (Following Initial Outpatient Treatment Period)

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

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

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

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

Case Managed Dialysis and Supplemental Kidney Dialysis

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

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

DURABLE MEDICAL EQUIPMENT

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

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

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

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

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

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening exams and treatment, routinely available ancillary evaluative services, and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. "Stabilization" means to provide Medically Necessary treatment: 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, who is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized.

If admitted to a participating or nonparticipating 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. If services were not covered at the Category 1 level, as described above, contact Customer Service for an adjustment to Your claims.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Category 1	Category 2	Category 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 10% of the Allowed Amount.	Payment: You pay 100% of the billed charges. Your payment will not be applied toward the Deductible or Out-of-Pocket Maximum.	Payment: You pay 100% of the billed charges. Your payment will not be applied toward the Deductible or Out-of-Pocket Maximum.

If You fulfill Medical Necessity criteria and receive therapy from a Provider expressly identified by the Claims Administrator as a Center of Excellence for that therapy, gene therapies and/or adoptive cellular

therapies and associated Medically Necessary Covered Services are covered under this benefit. You may contact the Claims Administrator for a current list of covered gene and cellular therapies or to identify a Center of Excellence.

Travel Expenses

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

GENETIC TESTING

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

HOME HEALTH CARE

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

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

HOSPICE CARE

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

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

special needs of a patient and his or her Family during the final stages of Illness. Respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant is also covered. Respite care days that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

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

Inpatient and outpatient services and supplies of a Hospital are covered for Illness and Injury (including Prescription Medications and services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to a participating or nonparticipating 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 when services are received from a nonparticipating Hospital. If You are admitted as an inpatient directly from the emergency room and services were not covered at the Category 1 level, as described above, contact Customer Service for an adjustment to Your claims.

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

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

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

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

MATERNITY CARE

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

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

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

Surrogacy

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

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

Definitions

The following definition applies to this Maternity Care benefit:

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

MEDICAL FOODS

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

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

MENTAL HEALTH SERVICES

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

Mental Health Services for treatment of Mental Health Conditions are covered. Applied Behavioral Analysis (ABA) therapy services are covered for treatment of Autism Spectrum Disorders (ASD) when Claimants seek services from licensed Providers qualified to prescribe and perform ABA therapy services. A diagnosis of ASD/PDD (Pervasive Developmental Disorder) must be made by an appropriate provider (neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or doctoral level psychologist) experienced in the diagnosis and treatment of autism. ABA therapy must be prescribed as appropriate for the patient and services must be Medically Necessary, meet Regence clinical criteria guidelines and providers must submit individualized treatment plans and progress evaluations.

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

Refer to the Care Management and Wellness Programs section for information on the Compsych Employee Assistance Program.

Definitions

The following definitions apply to this Mental Health Services benefit:

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

Mental Health Services means Medically Necessary outpatient services, Residential Care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), and court ordered treatment (unless the treatment is determined by the Claims Administrator to be Medically Necessary).

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

NEURODEVELOPMENTAL THERAPY

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 10% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Inpatient limit: unlimited Outpatient limit: 60 visits per Claimant per Calendar Year for all outpatient neurodevelopmental therapy services		

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

NEWBORN CARE

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

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

NUTRITIONAL COUNSELING

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 10% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: ten visits per Claimant Lifetime (diabetic education and counseling is not subject to this limit).		

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

ORTHOTIC DEVICES

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

Braces, splints, orthopedic appliances and orthotic supplies or apparatuses purchased to support, align or correct deformities or to improve the function of moving parts of the body are covered. The Plan covers custom molded shoe inserts and orthopedic shoes; the Plan does not cover off-the-shelf shoe inserts and off-the-shelf orthopedic shoes.

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

Reimbursement may also be available for new orthotic devices when obtained from an approved commercial seller, even though that seller is not a Provider. Eligible new orthotic devices purchased through an approved commercial seller are covered at the Category 1 level, with Your reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item.

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

PALLIATIVE CARE

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

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

- home health aide services for activities of daily living and personal care;
- medical services for pain and symptom management;
- psychological and social services such as family counseling, marital counseling and spiritual support visits;
- caregiver support; and
- advance care planning.

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

Palliative care visits that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. All other Covered Services for the Claimant receiving palliative care remain covered the same as any other Illness or Injury.

PROSTHETIC DEVICES

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

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

REHABILITATION SERVICES

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

Inpatient and outpatient rehabilitation services and accommodations to restore or improve lost function caused by Illness, Injury or disabling condition are covered. Rehabilitation services include massage, physical, occupational, and speech therapy necessary to help get the body back to normal health or function. A prescription is required for outpatient services. Coverage for massage therapy visits is limited to a maximum of 60 minutes per visit. Benefits will be provided for Maintenance Therapy in cases where significant deterioration in the Claimant's condition would result without the services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

RETAIL CLINIC OFFICE VISITS

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

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

SKILLED NURSING FACILITY (SNF) CARE

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

Inpatient services and supplies of a Skilled Nursing Facility are covered for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility services that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 10% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
Limit: 15 spinal manipulations per Claimant per Calendar Year		

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

SUBSTANCE USE DISORDER SERVICES

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

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

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

Definitions

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

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

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

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

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

TELEHEALTH

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After \$10 Copayment per visit, You pay 0% of the Allowed Amount.	Payment: After \$10 Copayment per visit, You pay 0% of the Allowed Amount.	Payment: You pay 100% of billed charges. Your payment will not be applied toward the Deductible or Out-of-Pocket Maximum.

The Plan covers telehealth (live audio-only communication, audio and video communication, and asynchronous (not live) store and forward services) office visits for primary care, including at home, as permitted by law, between the patient and a Category 1 or 2 Provider. Store and forward consultations between Category 1 or 2 Providers are also covered. Contact Customer Service for further information and guidance.

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

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

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

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

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

TELEMEDICINE

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

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

Provider's office; community mental health center; Skilled Nursing Facility; or renal dialysis center, except an independent renal dialysis center.

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

TOBACCO USE CESSATION

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

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

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. 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
Payment: After Deductible, You pay 10% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount.	Payment: After Deductible, You pay 30% of the Allowed Amount and You pay balance of billed charges.

Transplants, including Hospital or outpatient Facility Fees, transplant-related services and supplies are covered. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell 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).

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

Donor Organ Benefits

Donor organ procurement costs, including hospital or outpatient Facility Fees are covered, if the recipient is covered for the transplant under this Plan. Procurement benefits are limited to selection, removal of the

organ, storage, transportation of the surgical harvesting team and the organ and other such Medically Necessary procurement costs.

Prescription Medication Benefits

In this section, You will learn how Your Prescription Medication coverage works, including information about 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

• \$5 for each Generic Medication
• \$25 for each Preferred Brand-Name Medication on the Drug List
• \$50 for each Brand-Name Medication not on the Drug List
• \$50 for each Compound Medication
• \$100 for each Specialty Medication

For Prescription Medications from a Mail-Order Supplier

• \$10 for each Generic Medication
• \$50 for each Preferred Brand-Name Medication on the Drug List
• \$100 for each Brand-Name Medication not on the Drug List
• \$100 for each Compound Medication
• \$200 for each Specialty Medication

Maximum 30-Day or Greater Supply Limit

- **Specialty Medications.** The largest allowable quantity for a Specialty Medication purchased from a Pharmacy or Specialty Pharmacy is a 30-day supply, or from a Mail-Order Supplier is a 90-day supply. NOTE: Not all Specialty Medications are available in a 90-day supply, or from a Mail-Order Supplier.
- **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-Adminstrable Injectable Medications are limited to a 90-day supply as indicated above.
- **Pharmacy and 30-Day Supply.** Except as specifically provided below, a 30-day supply is the largest allowable quantity of a Prescription Medication that You may purchase from a 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 30-day supply within that multiple-month supply. Oral contraceptives can be purchased for a single Copayment per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one Copayment per monthly cycle.

Emergency Fill

You may be eligible to receive an Emergency Fill for Prescription Medications at no cost to You. A list of these medications is available on the Web site or by calling Customer Service. The cost share amounts noted in the Copayments section of the Prescription Medications Benefit Section apply to all other medications obtained through an Emergency Fill request as requested through Your Provider or by calling Customer Service. An Emergency Fill is only applicable when:

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

Drug List Changes

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

For information, visit the 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:

- Insulin and diabetic supplies (including, but not limited to, syringes, injection aids, test strips, glucagon emergency kits and prescriptive oral agents for controlling blood sugar levels, but not glucometers, insulin pumps and their supplies), when obtained with a Prescription Order (glucometers and 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;
- Non-preventive Prescription Medications for tobacco use cessation when obtained with a Prescription Order from a Participating Pharmacy;
- Prescription Medications;
- Emergency Fill five-day supply or the minimum packaging size available at the time the Emergency Fill is dispensed;
- foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States, except as may be provided under the Experimental/Investigational definition in the Definitions Section of this Booklet;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P & T) Committee;
- Compound Medications (preauthorization may be required);
- Self-Administerable Cancer Chemotherapy Medication;
- Self-Administerable Prescription Medications including, but not limited to, Self-Administerable Injectable Medications and teaching doses (by which a Claimant is educated to self-inject);

- 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, visit the Web site or contact Customer Service.

COVERED PREVENTIVE MEDICATIONS

The Plan covers certain Prescription Medications as preventive care:

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

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. 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.

Also, if Your Provider believes that the covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service.

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.

NOTE: FDA-approved over-the-counter contraceptive drugs, devices, and products are available from a Participating Pharmacy without a prescription and with no cost sharing. However, You must submit a claim for reimbursement for the purchase of such items.

Self-Adminstrable Cancer Chemotherapy Medication

The Plan covers Self-Adminstrable Cancer Chemotherapy Medications. You are not responsible for any Copayment when You fill prescriptions for Self-Adminstrable 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 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 any 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 any applicable 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 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.

Your Prescription Drug Rights

You have the right to safe and effective Pharmacy services. You also have the right to know what drugs are covered by Your plan and the limits that apply. If You have a question or concern about Your prescription drug benefits, contact 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. This list can be found on the Web site or by contacting 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, except for certain preventive medications as specified in the Covered Prescription Medications For Certain Preventive Prescription Medications 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. However, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription. Refills obtained from a 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, 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.

Manufacturer Coupons

Cost sharing savings that result from Your use of a drug manufacturer coupon for Prescription Medications will be applied to Your Out-of-Pocket Maximum. However, if application of any drug manufacturer coupon savings is found to have caused You to exceed Your Out-of-Pocket Maximum, You will not be refunded the coupon amount that exceeds Your Out-of-Pocket Maximum.

EXCLUSIONS

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

Biological Sera, Blood or Blood Plasma

Bulk Powders

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

Cosmetic Purposes

Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; anti-aging; repair of sun-damaged skin; or reduction of redness associated with rosacea.

Devices or Appliances

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

Diagnostic Agents

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

Foreign Prescription Medications

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

General Anesthetics

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

Glucometers

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

Insulin Pumps and Pump Administration Supplies

Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.

Medical Foods

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

Non-Self-Administrable Medications

Coverage for these medications may otherwise be provided under the Medical Benefits section or as specifically indicated in this Prescription Medications benefit.

Nonprescription Medications

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

Prescription Medications Dispensed in a Facility

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

Prescription Medications for the Treatment of Infertility**Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)****Prescription Medications Not Approved by the United States Food and Drug Administration (USFDA)****Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order****Prescription Medications Not within a Provider's License**

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

Prescription Medications with Lower Cost Alternatives

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

Prescription Medications without Examination

The Plan does not cover prescriptions made by a Provider without recent and relevant in-person, telehealth or telemedicine examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. 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**Repackaged Medications, Institutional Packs and Clinic Packs****DEFINITIONS**

The following definitions apply to this Prescription Medication Benefits Section:

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

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

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

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

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

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

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.

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

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included on 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, Self-Administrable Medications, Self-Administrable Injectable Medications, or Self-Administrable Cancer Chemotherapy Medications means a Prescription Medication labeled by the manufacturer as intended to be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician's office or clinic). For purposes of this definition, Self-Administrable Cancer Chemotherapy Medications include oral Prescription Medications used to kill or slow the growth of cancerous cells. Information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability is used to determine a Self-Administrable Medication. Your status, such as Your ability to administer the medication, will not be considered when determining whether a medication is self-administrable.

Specialty Medication means a medication that may be used to treat complex conditions, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of some of these medications, visit the Web site or contact Customer Service.

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

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, call 1 (866) 543-5765.

ALTERNATIVE BENEFITS

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

REGENGE CONDITION MANAGER

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

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

BABYWISE

Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. BabyWise 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 BabyWise is most beneficial when a woman enrolls early in her pregnancy, call 1 (888) JOY-BABY (569-2229) or send an e-mail to BabyWise@regence.com right away to get started.

REGENGE 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.

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

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

MDLIVE TELEHEALTH

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

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

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

HEALTH CENTRAL

Health Central is Your personalized, secure health and benefits resource. Employees and Your covered spouse/domestic partner with AWC Trust medical coverage can access wellness programs and tools, benefit plan booklets, summaries and wellness rewards. Health Central is available at awctrust.org or by downloading the Jiff/Castlight-Health Benefits app.

HEALTH ASSESSMENT

A confidential assessment of Your health status and health risks. Based on the answers You provide, the Assessment instantly reveals action steps You can take to improve Your health. Log in to Health Central at awctrust.org or download the Jiff/Castlight-Health Benefits app to find Your Assessment. The Health Assessment is available for employees, spouses and domestic partners.

HEALTH COACHING

Drive positive change in Your life and achieve Your goals. Digital or one-on-one telephonic coaching can help You stay on track. Choose one of the self-led digital programs, or begin working with Your own personal coach. Visit Health Central at awctrust.org or by downloading the Jiff/Castlight-Health Benefits app to view the self-led digital coaching options or schedule a one-on one coaching consultation. Health coaching is available for employees, spouses and domestic partners.

NATURALLY SLIM (WEIGHT MANAGEMENT PROGRAM)

Provides a digital behavioral counseling program for metabolic syndrome reversal, weight management and diabetes prevention. It combines a unique mindful-eating curriculum with technology to teach participants the skills needed to sustainably lose weight and improve overall health and well-being. The programs first session will be available to employees, spouses and domestic partners beginning June 3, 2019. The Naturally Slim sessions are run periodically throughout the year and have space limitations.

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

WELLNESS NEWSLETTER

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

General Exclusions

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

PREEXISTING CONDITIONS

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

SPECIFIC EXCLUSIONS

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.**

Activity Therapy

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

Assisted Reproductive Technologies

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

Certain Therapy, Counseling, and Training

Educational, vocational, social, image, milieu, or marathon group therapy, premarital or marital counseling, job skills or sensitivity training.

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Cosmetic Services and Supplies

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

Counseling

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

Custodial Care

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

Dental Services

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

Expenses Before Coverage Begins or After Coverage Ends

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

Family Counseling

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

Fees, Taxes, Interest

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

Government Programs

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

Growth Hormone Therapy

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

Hearing Aids, and Other Hearing Devices

Hearing aids, (externally worn or surgically implanted) and other hearing devices are excluded, except as otherwise specified. This exclusion does not apply to cochlear implants.

Hypnotherapy and Hypnosis Services

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

Illegal Services, Substances and Supplies

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

Individual Education Program (IEP)

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

Infertility Treatment

Treatment of infertility, including but not limited to surgery, uterine transplants, fertility drugs and medications.

Investigational Services

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

Motor Vehicle Coverage and Other Insurance Liability

Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant

makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to the Booklet.

Non-Direct Patient Care

Services that are not considered direct patient care, telemedicine or telehealth, including charges for:

- appointments scheduled and not kept ("missed appointments");
- preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at 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 Telehealth and Telemedicine benefits.

Obesity or Weight Reduction/Control

The Plan does not cover medical treatment, medications, surgical treatment (including revisions, reversals, and treatment of complications), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions, 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, light boxes and therapy or service animals, including the cost of training and maintenance, are not covered.

Physical Exercise Programs and Equipment

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

Private-Duty Nursing

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

Reversal of Sterilization

Services and supplies related to reversal of sterilization.

Riot, Rebellion, War and Illegal Acts

Services and supplies for treatment of an illness, injury or condition caused by a Claimant's **voluntary participation in** a riot, war, armed invasion or aggression, insurrection or rebellion or sustained by a Claimant arising directly from an act deemed illegal by an officer or a court of law.

Routine Foot Care

Routine Hearing Exams

Self-Help, Self-Care, Training or Instructional Programs

The Plan does not cover self-help, non-medical self-care, training programs, including:

- childbirth-related classes including infant care; and

- instructional programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

Services and Supplies Provided by a Member of Your Family

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

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

Services and Supplies That Are Not Medically Necessary

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

Services for Administrative or Qualification Purposes

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

Sexual Dysfunction

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

Surrogacy

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

Temporomandibular Joint (TMJ) Disorder Treatment

Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.

Third-Party Liability

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

Travel and Transportation Expenses

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

Vision Care

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

Wigs

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

Work-Related Conditions

Expenses for services and supplies incurred as a result of any work-related Illness or Injury, including any claims that are resolved related to a disputed claim settlement. 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 administration of benefits and claims, including situations where Your health care expenses are the responsibility of a source other than the Plan.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

Category 1 and Category 2 Claims and Reimbursement

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

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

Category 3 Claims and Reimbursement

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

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

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

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

NOTE: If You use a Nonparticipating Provider (Category 3), You cannot 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.

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.

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

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.

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Injury, Illness or condition to the full extent of benefits

provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

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

Constructive Trust

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

Lien Rights

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

Assignment

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

First-Priority Claim

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

Applicability to All Settlements and Judgments

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

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, Illness or condition. You and Your agents agree to provide the Plan or its representatives

notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

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

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

Workers' Compensation

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

Future Medical Expenses

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

Interpretation

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

Jurisdiction

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

MAINTENANCE OF BENEFITS

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

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

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

Definitions

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

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 coordination of benefits among those separate contracts. However, if coordination of benefits rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which coordination of benefits does not apply is treated as a separate plan.

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

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

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

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

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

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

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

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

- If You are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

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

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

Order of Benefit Determination Rules

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

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

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

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

- For a child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
- For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
 - If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;

- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The plan covering the Custodial Parent, first;

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

The plan covering the noncustodial parent, third; and then

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

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

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

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

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

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

Effect on the Benefits of this Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

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

Out-Of-Area Services

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

When care is received outside of the Claims Administrator's Service Area, it will be received from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") don't contract with the Host Blue. This section explains below how the Plan pays both kinds of Providers.

BlueCard Program

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

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

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

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

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

Value-Based Programs

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

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

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

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

Federal law or state law may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, any such surcharge, tax or other fee will be included as part of the claim charge passed on to the Claimant.

Nonparticipating Providers Outside the Claims Administrator's Service Area

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

BLUE CROSS BLUE SHIELD GLOBAL CORE

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global Core Claim**

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

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 (800) 752-9985.

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

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

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of 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.

Second-Level Appeals

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

VOLUNTARY EXTERNAL APPEAL - IRO

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

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will make its decision and provide You with its written determination within 45 days after their receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in

accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

The voluntary external Appeal by an IRO is optional and, to the extent other options or remedies are available under State or Federal law, other forums may be utilized as the final level of Appeal to resolve a dispute You have under the Plan.

There is no voluntary Appeal to the AWC Board of Trustees of the First-Level Appeal decision or the IRO Appeal decision.

EXPEDITED APPEALS

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

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

First-Level Expedited Appeal

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

Voluntary Expedited External Appeal - IRO

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

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

The voluntary expedited Appeal by an IRO is optional and, to the extent other options or remedies are available under State or Federal law, other forums may be used as the final level of expedited Appeal to resolve a dispute You have under the Plan.

There is no voluntary Appeal to the AWC Board of Trustees of the First-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 Customer Service at 1 (800) 752-9985 or You can write to Customer Service at the following address: Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

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

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

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

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

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

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, though payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

INITIAL ELIGIBILITY, WHEN COVERAGE BEGINS

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

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

Employees

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

Dependents

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

- The person to whom You are legally married (spouse).
- Your registered domestic partner and if specifically included as eligible by Your employer, Your non-registered domestic partner. Contact the AWC Trust for questions about whether Your non-registered domestic partner is eligible for the Plan.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
 - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
 - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
 - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or mental or physical disability that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity acceptable to the Plan, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
 - 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 the Web site or by calling Customer Service. The Claims Administrator may request updates on

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

SPECIAL ENROLLMENT

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

New Dependents

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

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

Loss of Other Coverage

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

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

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

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

Qualification for Premium Assistance

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

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

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

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

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

When Coverage Ends

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

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

MEMBER EMPLOYER TERMINATION

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

WHAT HAPPENS WHEN PARTICIPANTS ARE NO LONGER ELIGIBLE

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

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

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

NONPAYMENT

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

FAMILY AND MEDICAL LEAVE

If Your employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA"), 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, his or her coverage will end on the last day of the month in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions.

Divorce or Annulment

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

Death of the Enrolled Participant

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

Termination of Domestic Partnership

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

Loss of Dependent Status

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

OTHER CAUSES OF TERMINATION

Claimants may be terminated for any of the following reasons.

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

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

COBRA Continuation of Coverage

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

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

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

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce 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). (Note that plans will not be able to impose pre-existing condition limitations beginning in 2014). You or a family member must notify the AWC Trust in writing at the address listed below under "Notice Procedures" if a person on COBRA becomes entitled to Medicare or becomes covered under another group health plan within 30 days of such entitlement or coverage. However, COBRA coverage will not be terminated based on the fact that the individual had other group coverage (including Medicare) in place prior to electing COBRA. Non-payment of premiums will also terminate coverage at the end of a 31-day grace period.

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

Special considerations in deciding whether to elect COBRA

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

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

How to apply and pay for COBRA

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

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

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

Send a check or money order for the required premium for the appropriate month(s) to the address 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.

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 AWC Trust as described below: Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered addressed as follows:

Mail to:

AWC Employee Benefit Trust
c/o 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 and Legal Notices

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

CERTIFICATES OF CREDITABLE COVERAGE

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

CHOICE OF FORUM

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

GOVERNING LAW AND DISCRETIONARY LANGUAGE

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

LIMITATIONS ON LIABILITY

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

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

NO WAIVER

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

NONASSIGNMENT

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

NOTICES

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

NOTICE OF PRIVACY PRACTICES

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

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

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Definitions

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

PROVIDER DEFINITIONS

For Providers of care, we use the following terms:

Category 1 means the benefit reimbursement level for services that are received from a Contracted Provider that is in the Provider network: Preferred. Category 1 reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 1 Providers include only Our identified Centers of Excellence for the particular therapy.

Category 2 means the benefit reimbursement level for services that are received from a Contracted Provider that is in the Provider network: Participating. Category 2 reimbursement is generally a lower payment level than Category 1, but You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 2 Providers include any Provider that is not one of Our identified Centers of Excellence for the particular therapy.

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

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

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

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

Practitioner means a healthcare professional, other than a Physician, who is duly licensed to provide medical or surgical services. Practitioners include, but are not limited to, chiropractors, psychologists, registered nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or doctor of dental surgery, or a dentist) and other professionals practicing within the scope of their respective licenses, such as massage therapists, physical therapists and mental health counselors.

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

GENERAL DEFINITIONS

Allowed Amount means:

- For preferred and participating Providers, the amount that they have contractually agreed to accept as full payment for a service or supply.

- For Non-Contracted (nonparticipating) Providers, the amount the Claims Administrator has determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges, as determined by the Claims Administrator, or as otherwise required by law. Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact the Claims Administrator.

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

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.

Experimental/Investigational means a Health Intervention that the Claims Administrator has classified as Experimental or Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in Peer-Reviewed Medical Literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is

Experimental or Investigational. A Health Intervention not meeting all of the following criteria, is, in the Claims Administrator's judgment, Experimental or Investigational:

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

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

Family means a Participant and his or her Beneficiaries.

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

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

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

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

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

Injury means physical damage to the body 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.

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

Regence refers to Regence BlueShield.

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

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

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

Service Area means 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 serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

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