2026 BOOKLET FOR:

KING COUNTY

DS KingCare Select UW Medicine

Group Number: 10017241

Medical Benefits

Regence

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1-800-985-3059.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages.

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

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

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

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

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

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

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

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

This Booklet provides the written description of the terms and benefits of coverage available under the Plan. The administrative services contract between Your employer and Regence BlueShield (called the "Agreement") contains all the terms of coverage. Your employer has a copy.

This Booklet describes benefits effective **January 1, 2026**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueShield and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the term "Claims Administrator" refers to Regence BlueShield and the term "Plan Sponsor" refers to Your employer. References to "You" and "Your" refer to the Participant and/or Beneficiaries. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

EMPLOYER PAID BENEFITS

This self-funded group health plan (hereafter referred to as "Plan") is an employer-paid benefits plan administered by the Claims Administrator. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. 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 the Claims Administrator with the funds to pay Your benefits and pay all other charges due under the Plan.

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

CONTACT INFORMATION

Customer Service: 1-800-376-7926
(TTY: 711)

Phone lines are open Monday through Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. to 4:30 p.m., Pacific time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- to request a copy of Your identification card or print a copy via the Claims Administrator's website if You have not received or have lost Your identification card;
- if You would like to request written or electronic information regarding any other plan that the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's website, **regence.com**, to submit a claim online or chat live with a Customer Service representative;
- to access a list of contracted health care benefit managers acting on the Claims Administrator's behalf in the utilization of health care services, which can be found at **regence.com/member/members/member-notices**; or
- for assistance in a language other than English.

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

BlueCard® Program: This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueShield serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Call Customer Service to learn how to have access to care through the BlueCard Program.

Ventegra: Customer Service: 1-844-571-2982. Claims Department: Ventegra, Inc.10400 Overland Road, Box #353, Boise, ID 83709.

Using Your Booklet

ACCESSING PROVIDERS

For each benefit, the Provider You may choose and Your payment amount for each Provider option is indicated. See the Definitions Section for a complete description of In-Network and Out-of-Network. You can go to **regence.com** for further Provider network information.

In-Network Benefit

You will receive a higher level of benefit when You see Providers in Your network (In-Network Providers) for Covered Services. Your Provider Network is: UW Medicine. To use Your plan, do the following:

- Select a Primary Care Provider from Your network for Yourself and any family members. If You do not select a Primary Care Provider, the Claims Administrator will select one. Contact the Claims Administrator if You need help finding a Primary Care Provider.
- When You need care, contact Your Primary Care Provider first. Your Provider will treat You and determine if You need to seek more specialized care and may refer You to a Specialist, if necessary. Referrals are not required for specialty care, but Your Primary Care Provider can help manage Your care.
- If You need to be admitted as an inpatient for care at a Hospital or clinic for non-emergent care, Your Primary Care Provider may handle all arrangements with the facility.

Out-Of-Network Benefit

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

ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to the Claims Administrator's website and mobile application to help You navigate Your way through health care decisions. For access, You just set up Your free account once and it is always up to You whether to participate. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR BOOKLET.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of the Booklet.

- **Go to regence.com** or the Claims Administrator's mobile application. You can use the Claims Administrator's secure applications to:
    - view recent claims, benefits and coverage;
    - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
    - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs; and
    - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. The Claims Administrator has contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*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.

Table of Contents

UNDERSTANDING YOUR BENEFITS 1

MAXIMUM BENEFITS 1
DEDUCTIBLES 1
COPAYMENTS 1
COINSURANCE (PERCENTAGE YOU PAY) 1
BALANCE BILLING 2
OUT-OF-POCKET MAXIMUM 2
HOW CALENDAR YEAR BENEFITS RENEW 3

MEDICAL BENEFITS 4

CASE MANAGEMENT 4
PREAUTHORIZATION 4
PREVENTIVE VERSUS DIAGNOSTIC SERVICES 5
CALENDAR YEAR DEDUCTIBLES 5
CALENDAR YEAR OUT-OF-POCKET MAXIMUM 5
PREVENTIVE CARE AND IMMUNIZATIONS 6
OFFICE OR URGENT CARE CENTER VISITS – ILLNESS OR INJURY 7
RADIOLOGY AND LABORATORY SERVICES 7
OTHER PROFESSIONAL SERVICES 8
ACUPUNCTURE 9
AMBULANCE SERVICES 9
AMBULATORY SURGICAL CENTER 10
APPROVED CLINICAL TRIALS 10
BARIATRIC SERVICES 11
BLOOD BANK 11
DENTAL HOSPITALIZATION 11
DIABETIC EDUCATION 11
DIALYSIS 11
DURABLE MEDICAL EQUIPMENT 13
EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES) 13
FERTILITY TREATMENT 14
HEARING AIDS AND EVALUATIONS 14
HOME HEALTH CARE 15
HOSPICE CARE 15
HOSPITAL CARE 15
INFUSION THERAPY 16
MATERNITY CARE 16
MEDICAL FOODS 17
MENTAL HEALTH SERVICES 17
NEURODEVELOPMENTAL THERAPY 18
NEWBORN CARE 18
NUTRITIONAL COUNSELING 18
ORTHOTIC DEVICES 19
PALLIATIVE CARE 19
PENILE PROSTHESES 20
PROSTHETIC DEVICES 20
RECONSTRUCTIVE SERVICES AND SUPPLIES 20
REHABILITATION SERVICES 21
REPAIR OF TEETH 21
REPRODUCTIVE HEALTH CARE SERVICES 21
ROUTINE HEARING EXAMINATIONS 22
SKILLED NURSING FACILITY 22

SPINAL MANIPULATIONS 22
SUBSTANCE USE DISORDER SERVICES 22
TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS 23
TOBACCO USE CESSATION 24
TRANSPLANTS 24
TRAVEL EXPENSES FOR GENDER AFFIRMING TREATMENT 25
TRAVEL EXPENSES FOR MEDICAL AND SURGICAL SERVICES 26
VIRTUAL CARE 26

GENERAL EXCLUSIONS 28

SPECIFIC EXCLUSIONS 28

CLAIMS ADMINISTRATION 34

SUBMISSION OF CLAIMS AND REIMBURSEMENT 34
CONTINUITY OF CARE 35
PRIOR APPROVAL OF OUT-OF-NETWORK PROVIDERS 35
OUT-OF-AREA SERVICES 35
BLUE CROSS BLUE SHIELD GLOBAL® CORE 37
CLAIMS RECOVERY 37
RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY 37
MAINTENANCE OF BENEFITS 41

APPEAL PROCESS 45

WHAT YOU MAY APPEAL 45
APPEAL DETERMINATION TIMING 45
INTERNAL APPEALS 46
VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO) 46
EXPEDITED APPEALS 46
INFORMATION 47
DEFINITIONS SPECIFIC TO THE APPEAL PROCESS 47

ELIGIBILITY APPEALS 48

ELIGIBILITY AND ENROLLMENT 49

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS 49
NEWLY ELIGIBLE DEPENDENTS 50
SPECIAL ENROLLMENT 50
ANNUAL OPEN ENROLLMENT PERIOD 51
DOCUMENTATION OF ELIGIBILITY 51
RETIREE ELIGIBILITY 51

WHEN COVERAGE ENDS 53

AGREEMENT TERMINATION 53
WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE 53
WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE 53
OTHER CAUSES OF TERMINATION 54
FAMILY AND MEDICAL LEAVE 54
FAMILY AND MEDICAL LEAVE - OTHER 54
MILITARY LEAVE OF ABSENCE 54
LEAVE OF ABSENCE WITHOUT PAY 55

COBRA CONTINUATION OF COVERAGE 56

OTHER CONTINUATION OPTIONS 57

GENERAL PROVISIONS AND LEGAL NOTICES 58

CHOICE OF FORUM 58
GOVERNING LAW AND DISCRETIONARY LANGUAGE 58
LIMITATIONS ON LIABILITY 58
NO WAIVER 58
NONASSIGNMENT 58
NOTICES 58
NOTICE OF PRIVACY PRACTICES 59
PLAN SPONSOR IS AGENT 59
RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION 59
REPRESENTATIONS ARE NOT WARRANTIES 59
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS 59
STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 60
TAX TREATMENT 60
WHEN BENEFITS ARE AVAILABLE 60
WOMEN'S HEALTH AND CANCER RIGHTS 60

DEFINITIONS 61

APPENDIX: VALUE-ADDED SERVICES 66

CONDITION MANAGER 66
DIABETES MANAGEMENT 66
DIABETES PREVENTION 66
HYPERTENSION MANAGEMENT 66
NURSE ADVICE 66
REGENCE EMPOWER 66

YOUR PRESCRIPTION MEDICATION BENEFITS ADMINISTERED BY VENTEGRA 68

Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Medical Benefits Section to see what Your benefits are.

MAXIMUM BENEFITS

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

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

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before the Plan will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is an individual (per Claimant) Deductible amount and a Family Deductible amount for In-Network benefits and also for Out-of-Network benefits.

The Family Deductible is satisfied when any combination of Family members' payments toward each of their individual Deductibles total the Family Deductible amount. No one Family member may contribute more than their individual Deductible amount toward the Family Deductible in a Calendar Year. A Family member does not have to satisfy their individual Deductible if the Family Deductible has already been satisfied.

The Plan does not pay for services applied toward the Deductible. Refer to the benefits section to see what Covered Services are subject to the Deductible. Except as specifically noted otherwise, any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible.

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 the Deductible during the last three months will be carried forward and applied toward the Deductible for the following year. If the amount applied toward the Deductible for a Claimant in the last three months of a Calendar Year is greater than the Claimant's individual Deductible in the following year (because the following year's Deductible is lower), then the Claimant's individual Deductible for that following year is met. Further, the full amount applied toward the Claimant's individual Deductible in the last three months of the previous year is applied to the Family Deductible for the following year.

COPAYMENTS

Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. A Provider may or may not request any applicable Copayment at the time of service. Refer to the benefit sections to see what Covered Services are subject to a Copayment.

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

COINSURANCE (PERCENTAGE YOU PAY)

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

An In-Network Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers may bill You for any balances over the Plan's payment level in addition to any Deductible, Copayment and/or Coinsurance amount (referred to as balance billing).

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

BALANCE BILLING

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

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

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

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. There is an individual (per Claimant) Out-of-Pocket Maximum amount and a Family Out-of-Pocket Maximum amount for In-Network benefits and also for Out-of-Network benefits. Out-of-Pocket expenses will apply toward both the In-Network and Out-of-Network Out-of-Pocket limit.

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

A Claimant's payment of any Deductible, Copayment and/or Coinsurance for ambulance, blood bank, emergency room services, and travel benefits for specified benefits will apply toward the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance does not change to a higher payment level or apply to the Out-of-Pocket Maximum for some benefits. Refer to the benefit sections to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

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

HOW CALENDAR YEAR BENEFITS RENEW

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

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

Medical Benefits

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

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. Benefits for Gender Affirming Treatment are covered the same as any other Covered Services (to the extent such services are permitted under applicable law), regardless of an individual's sex assigned at birth, gender identity or expression. All covered benefits are subject to the limitations, exclusions and provisions of this Plan. In some cases, benefits or coverage may be limited to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

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

Reimbursement may be available for new medical supplies, equipment, and devices You purchase from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. New medical supplies, equipment, and devices, such as a wheelchair or breast pumps, purchased through an approved Commercial Seller are covered at the In-Network Provider level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item, or the retail market value for that item. To learn more about how to access an approved Commercial Seller and reimbursable new retail medical supplies, equipment, and devices, visit the Claims Administrator's website or contact Customer Service.

If You choose to access new medical supplies, equipment, and devices through the Claims Administrator's website, 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.

CASE MANAGEMENT

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

PREAUTHORIZATION

Some Covered Services may require preauthorization. Those services require contracted Providers to obtain preauthorization from the Claims Administrator before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from the Claims Administrator in advance and the service is 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 responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

A complete list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Claims Administrator's website at: regence.com/web/regence_provider/pre-authorization or by calling 1-800-376-7926.

Time Frame for Response

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

When More Information is Needed to Make a Determination

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

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

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

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

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

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

CALENDAR YEAR DEDUCTIBLES

In-Network

Per Claimant: $100
Per Family: $300

Out-of-Network

Per Claimant: $500
Per Family: $1,500

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

In-Network

Per Claimant: $900
Per Family: $1,900

Out-of-Network

Per Claimant: $2,500
Per Family: $5,500

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic, or other public health emergency. 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.

Covered Services that do not meet the above criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered elsewhere in the Medical Benefits Section. For a list of Covered Services, including information about obtaining new breast pumps from an approved Commercial Seller, visit the Claims Administrator's website or contact Customer Service.

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

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Preventive care services provided by a professional Provider, facility or Retail Clinic are covered in this benefit:

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

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

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

If You choose to access new medical supplies, equipment, and devices through Our website, We may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

Immunizations – Adult

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Immunizations – Childhood (Through 18 Years of Age)

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** No charge up to the Allowed Amount and You pay any balance of billed charges.

Immunizations – Influenza, Measles, Mumps and Rubella

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** You pay 0% of billed charges.

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

Expanded Immunizations

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

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

OFFICE OR URGENT CARE CENTER VISITS – ILLNESS OR INJURY

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $20 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

RADIOLOGY AND LABORATORY SERVICES

Inpatient Services

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

Outpatient Services

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

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

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

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

Diagnostic and supplemental breast examinations that meet the following criteria are not subject to any cost-sharing when received from an In-Network Provider:

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

"Complex imaging" means:

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

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

OTHER PROFESSIONAL SERVICES

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

Services and supplies provided by a professional Provider are covered, subject to any specified limits 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.

Medical Services and Supplies

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

Services and supplies also include:

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

Additionally, certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller.

Benefits for eligible new supplies will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

Professional Inpatient, Outpatient

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

Radiation Therapy, Respiratory Therapy and Chemotherapy

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

Surgical Services

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

Therapeutic Injections

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

ACUPUNCTURE

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

Acupuncture visits are covered. For acupuncture to treat Substance Use Disorder Conditions or tobacco cessation withdrawal, refer to the Substance Use Disorder Services and Tobacco Use Cessation benefits.

AMBULANCE SERVICES

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

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

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

AMBULATORY SURGICAL CENTER

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

Outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury.

APPROVED CLINICAL TRIALS

If You are accepted as a trial participant in an Approved Clinical Trial, Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits Section. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Additional specified limits are as further defined.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

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

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

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

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

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

BARIATRIC SERVICES

Office Visits

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $20 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Bariatric Surgery

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

Bariatric office visits are covered. Bariatric surgery to treat obesity is covered only after the Claims Administrator evaluates and approves that the surgery is meeting its published medical policy.

Complications, revisions and reversals are covered the same as any other Illness or Injury.

BLOOD BANK

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

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

DENTAL HOSPITALIZATION

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

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

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** No charge up to the Allowed Amount and You pay any balance of billed charges.

Services and supplies for diabetic self-management training and education are covered. Diabetic nutritional counseling and therapy are covered.

DIALYSIS

Services and supplies for outpatient and home dialysis are covered as described below. Dialysis received while inpatient is covered elsewhere in the Medical Benefits Section, such as the Hospital Care benefit.

Outpatient Initial Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: three months per Claimant (42 treatments of hemodialysis or 30 days peritoneal dialysis) for the initial treatment period	

Hemodialysis, peritoneal dialysis and hemofiltration services, supplies, medications, labs and Facility Fees are covered during the initial treatment period when Your Physician prescribes outpatient dialysis. You should first contact the Claims Administrator to begin Case Management. A case manager will help You enroll in the Supplemental Kidney Dialysis Program. The "Supplemental Kidney Dialysis Program" is a supplemental program available to Claimants following the initial treatment period.

The "initial treatment period" will be three months of hemodialysis (42 treatments) or peritoneal dialysis (30 days). Once the initial treatment period limit is reached, outpatient dialysis may be covered according to the Outpatient Supplemental Treatment Period benefit below. If more than three months of treatment is necessary in the initial treatment period, the Claims Administrator must be contacted to approve the additional treatment and document Your progress.

Services that are rendered outside the country are covered, even if You have enrolled in the Supplemental Kidney Dialysis Program.

Outpatient Supplemental Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: No charge. 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 the balance of billed charges, which will not apply toward the Out-of-Pocket Maximum.

Supplemental treatment is covered for any outpatient dialysis that is required beyond the initial treatment period.

In addition, a Claimant receiving supplemental dialysis is eligible to have Medicare Part B premiums reimbursed as an eligible expense for the duration of the Claimant's dialysis treatment, as long as the Claimant continues to be enrolled in 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 Program

Receive one-on-one help and support in the event Your Physician prescribes 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 enroll in Case Management, call 1-800-376-7926.

DURABLE MEDICAL EQUIPMENT

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

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

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

Reimbursement may also be available for new Durable Medical Equipment when obtained from an approved Commercial Seller, even though this entity is not a Provider. Eligible new Durable Medical Equipment purchased through an approved Commercial Seller is covered at the In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To find ways to access new Durable Medical Equipment, including how to access an approved Commercial Seller, visit the Claims Administrator's website or contact Customer Service. If You choose to access new Durable Medical Equipment through the Claims Administrator's website, 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.

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $200 Copayment per visit and after 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:** You pay $200 Copayment per visit and after In-Network 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.

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

"Stabilization" means to provide Medically Necessary treatment:

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

If You are admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. If services were not covered at the In-Network level, contact Customer Service for an adjustment to Your claims.

FERTILITY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: $25,000 per Claimant per Lifetime (limit does not apply to artificial insemination)	

Surgical and nonsurgical treatment is covered for the diagnosis and correction of infertility. Additionally, assisted reproductive procedures, regardless of an infertility diagnosis, are covered, including:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer; and
- any associated surgery, testing or supplies.

Coverage does not include uterine transplants.

U.S. Food and Drug Administration (FDA) approved prescription medications indicated to treat infertility will be covered up to a $10,000 lifetime benefit limit. Keep in mind that Your Provider must write a prescription and it must be filled at a network pharmacy as specified in Your Prescription Medication Benefits Administered By Ventegra at the end of this Booklet. Additionally, there may be some prescription medications that are administered by a Provider in a medical office that may be limited to coverage under Your medical benefits.

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

HEARING AIDS AND EVALUATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: No charge up to the limits outlined below.	**Payment:** No charge up to the limits outlined below.
Limit: 1 hearing aid per ear every 36 months	

Hearing aids and any associated evaluations are covered when necessary for treatment of hearing loss. Covered Services include the following:

- over-the-counter hearing aids (including batteries and evaluations);
- bone conduction sound processors (including examinations and fittings). Implantation and associated surgical services are covered in the Other Professional Services benefit;
- ear molds and replacement ear molds;
- hearing aid checks and testing;
- rentals; and
- repairs.

"Hearing aid" means any nondisposable, wearable instrument designed to aid or compensate for impaired human hearing and any necessary part or ear mold for the instrument.

Cochlear implants are covered the same as any other Illness or Injury.

Covered Services do not include:

- routine hearing examinations;
- hearing assistive technology systems; or
- the cost of cords.

HOME HEALTH CARE

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

Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Private-duty nursing is also covered.

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

HOSPICE CARE

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

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

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

HOSPITAL CARE

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

Inpatient and outpatient services and supplies of a Hospital (including prescription medications and services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If You are admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. Please contact Customer Service for further information and guidance.

INFUSION THERAPY

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

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

Certain medications for outpatient infusion therapy may require preauthorization. Additionally, for coverage to be provided, preauthorization for some medications requires that infusion therapy be performed at an approved site of care, unless an exception is authorized. Site of care review is part of the Claims Administrator's preauthorization process and may be a factor used to determine Medical Necessity.

"Approved site of care" means a Provider (such as standalone infusion sites, doctor's offices, home infusion or an approved Hospital-based infusion center) with which the Claims Administrator has expressly identified or contracted to provide outpatient infusion therapy services in a more convenient, less costly manner while maintaining safety and efficiency. Contact Customer Service to verify which medications for outpatient infusion therapy require preauthorization and which Providers are an approved site of care.

MATERNITY CARE

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

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

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

Surrogacy

Maternity and related medical services received by You while Acting as a Surrogate are not Covered Services, up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. By incurring and making claim for such services, You agree to reimburse 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 Right of Reimbursement and Subrogation Recovery provision.

Definitions
The following definition applies to this Maternity Care benefit:

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

MEDICAL FOODS

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

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

MENTAL HEALTH SERVICES

Inpatient Services

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

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $20 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Other Outpatient Services

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

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

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

Marital and family counseling is also covered.

Definitions
The following definitions apply to this Mental Health Services benefit:

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

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

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

NEURODEVELOPMENTAL THERAPY

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

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

NEWBORN CARE

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

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

NUTRITIONAL COUNSELING

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

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

ORTHOTIC DEVICES

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

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

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

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

To learn more about how to access reimbursable new retail orthotic devices, including how to access an approved Commercial Seller, visit the Claims Administrator's website or contact Customer Service. If You choose to access new orthotic devices through the Claims Administrator's website, 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.

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

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

Custom Orthotic Braces

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

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

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

PALLIATIVE CARE

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

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

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

PENILE PROSTHESES

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

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

PROSTHETIC DEVICES

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

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

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

Covered Services also include:

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

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

RECONSTRUCTIVE SERVICES AND SUPPLIES

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

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

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

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

REHABILITATION SERVICES

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

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

REPAIR OF TEETH

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

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

REPRODUCTIVE HEALTH CARE SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Termination of pregnancy and related conditions are covered (to the extent such services are permitted under applicable law). The following FDA-approved contraceptive devices, products, and services are also covered when provided by a Physician or Practitioner:

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

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

ROUTINE HEARING EXAMINATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $20 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: one routine hearing examination per Claimant per Calendar Year	

Routine hearing examinations are covered.

SKILLED NURSING FACILITY

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

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

SPINAL MANIPULATIONS

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

Spinal manipulations are covered. Manipulations of extremities are covered in the Rehabilitation Services benefit.

SUBSTANCE USE DISORDER SERVICES

Inpatient Services

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

Outpatient Office/Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $20 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Other Outpatient Services

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

Substance Use Disorder Services are covered for treatment of Substance Use Disorders. Covered Services include:

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

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

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

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

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

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

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

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and

- not Experimental or primarily for Cosmetic purposes.

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

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

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

TOBACCO USE CESSATION

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.

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

TRANSPLANTS

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

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

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

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

Donor Organ Benefits

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

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

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.
Limit: $7,500 per Claimant per course of treatment (limit is combined for Claimant and companion(s)). Additional limitations included below.

Transportation and lodging expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States as verified through Your case manager, the transplant would require an overnight stay that is greater than 50 miles away from home and within reasonable proximity to the treatment area;
- based on a transplant episode beginning up to five days prior to the transplant and ending three months post-transplant (or sooner if the Claimant is cleared by the treating Provider to return home);
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19); and
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the transplant treatment. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Case Management for further information and guidance.

Coverage does not include travel expenses for the donor, meals, or expenses outside of transportation and lodging.

TRAVEL EXPENSES FOR GENDER AFFIRMING TREATMENT

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.
Limit: $7,500 per Claimant per course of treatment, including companion, for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered, for the purpose of receiving Covered Services not available in the Claimant's state of residence due to a legal restriction, subject to the following specified limits. Travel expenses will not be covered if payment for such expenses is illegal under applicable law.

- coverage is limited to travel expenses for Covered Services associated with Gender Affirming Treatment surgical procedures;
- coverage is limited to the Claimant and up to one companion (or two companions if the Claimant is under the age of 19); and
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class bus fare;
    - commercial coach class train fare; or

- auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. Documentation of all travel expenses and Covered Services received must be retained and submitted for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

These travel benefits are separate and distinct from any other travel benefits described elsewhere in this Booklet. Coverage does not include meals or expenses outside of transportation and lodging or travel outside of the United States of America.

TRAVEL EXPENSES FOR MEDICAL AND SURGICAL SERVICES

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.
Limit: $2,000 per Claimant per occurrence, including companion(s), for transportation and lodging expenses. Additional limitations included below.

Transportation and lodging expenses are covered, for the purpose of receiving Covered Services not available within 100 miles of the Claimant's residence, subject to the following specified limits. Travel expenses will not be covered if payment for such expenses is illegal under applicable law.

- coverage is limited to the Claimant and up to one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Claimant, not to exceed $100 per night for the Claimant and companion(s) combined) and;
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class bus fare;
    - commercial coach class train fare; or
    - auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. Documentation of all travel expenses and Covered Services received must be retained and submitted for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

These travel benefits are separate and distinct from any other travel benefits described elsewhere in this Booklet. Coverage does not include meals or expenses outside of transportation and lodging or travel outside of the United States of America.

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition.

Some Providers or virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share. "Virtual care vendors" mean a select group of Providers that have entered into an agreement with the Claims Administrator to provide virtual care services at a lower cost. To learn more about how to access virtual care services or Providers and virtual care vendors that may offer lower-cost services, visit the Claims Administrator's website or contact Customer Service.

Store and Forward Services

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

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

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

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

Telehealth

Provider: Doctor on Demand	Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** You pay $10 Copayment per visit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

General Exclusions

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

SPECIFIC EXCLUSIONS

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

- an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury; or
- a preventive service as specified in the Preventive Care and Immunizations benefit.

Activity Therapy

The following activity therapy services are not covered:

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

Adventure, Outdoor, or Wilderness Interventions and Camps

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

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

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

Assisted Reproductive Technologies

Except as provided in the Fertility Treatment benefit, assisted reproductive technologies (regardless of underlying condition or circumstance) or other artificial means of conception are not covered.

Certain Therapy, Counseling and Training

The following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;

- self-esteem;
- milieu or marathon group therapy;
- premarital counseling;
- employee assistance program services; and
- job skills or sensitivity training.

Conditions Caused by Active Participation in a War or Insurrection
The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

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

Cosmetic Services and Supplies
This exclusion does not apply to services that are prescribed as Medically Necessary for Gender Affirming Treatment, to the extent such services are permitted under applicable law and are in accordance with accepted standards of care.

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

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

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

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

Family Planning
Except as covered in Your Prescription Medication Benefits Administered By Ventegra at the end of this Booklet, over-the-counter contraceptive supplies are not covered.

Fees, Taxes, Interest
Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

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

Additionally, except as listed below, government facilities or government facilities outside the service area are not covered:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Hearing Aids and Other Devices
Except for cochlear implants or as provided in the Hearing Aids and Evaluations benefit, hearing aids (externally worn or surgically implanted) or other hearing devices are not covered.

Infertility
Except as provided in the Fertility Treatment benefit or to the extent Covered Services are required to diagnose such condition, treatment of infertility and uterine transplants are not covered.

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

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Refer to the expanded definition of Experimental/Investigational in the Definitions Section.

Motor Vehicle 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
Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Obesity or Weight Reduction/Control
Except as provided in the Nutritional Counseling or Bariatric Services benefit, as required as part of the USPSTF, HRSA, or CDC requirements, or as required by law, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

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

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

- temporomandibular joint disorder;
- orthognathic surgery due to an Injury;
- sleep apnea (specifically, telegnathic surgery);

- developmental anomalies; or
- congenital anomalies.

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

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

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

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

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

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

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

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

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

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

"Immediate family" means:

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

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

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

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

- admission to or remaining in:
    - school;
    - a camp;
    - a sports team;
    - the military; or
    - any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
    - employment or return to work;
    - marriage;
    - insurance;
    - occupational injury benefits;
    - licensure; or
    - certification.
- travel, immigration or emigration.

Sexual Dysfunction
Except as provided in the Mental Health Services benefit and except for penile prosthesis when impotence is caused by a covered medical condition, treatment, services and supplies (including medications) are not covered for or in connection with sexual dysfunction regardless of cause.

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

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

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

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

Travel and Transportation Expenses
Except as provided in the Ambulance Services benefit or as otherwise provided in the Transplants benefits, Travel Expenses for Gender Affirming Treatment, and Travel Expenses for Medical and Surgical Services, travel and transportation expenses are not covered.

Vision Care
Vision care services are not covered, including, but not limited to:

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

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

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

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

In-Network Provider Claims and Reimbursement

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

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

Out-of-Network Provider Claims and Reimbursement

In order for the Claims Administrator to pay for Covered Services, You or the Out-of-Network Provider must first send the Claims Administrator a claim. Be sure the claim is complete and includes the following information:

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

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the Claims Administrator the claim.

The Claims Administrator's standard policy is to make payment for Out-of-Network Provider claims directly to the Provider or, with submission of sufficient documentation that the Claimant has already "paid in full," solely to the Claimant.

Out-of-Network Providers have not agreed to accept the Allowed Amount as payment in full for Covered Services. You may be responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to any Deductible, Copayment and/or Coinsurance. However, for Out-of-Network Providers that have a contract with the Claims Administrator as participating providers inside the Regence BlueShield service area, You will not be billed for any difference between the billed amount and the Allowed Amount. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Timely Filing of Claims

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

Claim Determinations

Within 30 days of 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 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 of 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.

CONTINUITY OF CARE

You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if Your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud).

To qualify for continued coverage, You must be:

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

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

PRIOR APPROVAL OF OUT-OF-NETWORK PROVIDERS

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

If the Out-of-Network Provider does not have a contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Licensee, You may be responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount, in addition to any amount You must pay due to any Deductible, Copayment and/or Coinsurance. Any amounts You pay for non-Covered Services or in excess of the Allowed Amount do not apply toward the Deductible or Out-of-Pocket Maximum. Contact Customer Service for further information and guidance.

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

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.

When You receive care outside of the Claims Administrator's Service Area, You may receive it from Providers as described below. Providers contracted with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the In-Network Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the Out-of-Network Provider level and may bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Some Providers ("Out-of-Network Providers") don't contract with the Host Blue.

BlueCard Program

In 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 contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Providers that participate in the BlueCard Program.

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" is a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Provider or a group of Providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of Providers. Host Blues may use several factors to set an estimated or average price, including types of settlements, incentive payments, and/or other credits or charges. Estimated and average pricing may also take into account adjustments to correct Host Blue estimates of past prices. However, such adjustments will not affect the price used for the Claimant's claim because those adjustments will not be applied after a claim has already been paid.

Value-Based Programs

You may receive Covered Services under a Value-Based Program ("VBP") inside a Host Blue's service area. Host Blue may pay Providers that participate in a VBP for reaching agreed-upon cost and quality goals, meeting outcome measures, and coordinating care between its Providers. You will not be responsible for paying fees associated with a VBP, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

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

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

Out-of-Network Providers Outside the Claims Administrator's Service Area

When Covered Services are provided outside of the Claims Administrator's Service Area by Out-of-Network Providers, the amount the Claimant pays will normally be based on either Host Blue's Out-of-Network Provider local payment or pricing arrangements required by applicable state law. Other payment methods may be used in certain situations, such as billed charges for Covered Services, 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 Out-of-Network Providers. In any of these situations, the Claimant may be responsible for the difference between the Out-of-Network Provider's billed amount and the Plan's payment for Covered Services. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global® Core ("BCBS Global® Core") when accessing Covered Services. BCBS Global® Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although BCBS Global® Core helps you access a provider network, the network is not served by a Host Blue.

You may have to pay the Provider upfront and submit any claims to the Claims Administrator Yourself in order to obtain reimbursement for those services. When You pay for Covered Services outside the United States, You should complete and submit a BCBS Global® Core claim form with the Provider's itemized bill(s) to the service center (address is on the form) to initiate claims processing. If You contact the BCBS Global® Core service center for assistance, in most cases, Hospitals will not require You to pay for covered inpatient services (except for any applicable Deductible, Copayment, and/or Coinsurance). In such cases, the Hospital will also submit Your claims to the service center.

If You need medical assistance services or help locating a Provider outside the United States, or if You need assistance with a 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. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary. The claim form is available from the Claims Administrator, the service center, or online at **www.bcbsglobalcore.com**.

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

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 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 Right of Reimbursement and Subrogation Recovery provision for additional information.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

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

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

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

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

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

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

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

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

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

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

- By accepting benefits under this Plan, You or Your representative agree to notify the Plan promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by You.
- You or Your representative agrees to cooperate with the Plan and do whatever is necessary to secure their rights of subrogation and reimbursement under this Booklet. In addition, You or Your representative agrees to do nothing to prejudice the Plan's subrogation and reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the Plan.
- If a claim for health care expense is filed with the Plan and You have not yet received recovery from the responsible third party, the Plan may advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the third party in trust for the Plan, up to the amount of benefits the Plan paid in connection with the Illness or Injury.

- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to the Plan's right of subrogation or reimbursement segregated in its own account, until the Plan's right is satisfied or released.
- Further, You or Your representative give the Plan a lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by law to the full cost of all benefits associated with Third Party Injuries provided by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- You or Your representative also agrees to pay from any recovery, settlement, judgment or other source of compensation, any and all amounts due the Plan as reimbursement for the full cost of all benefits, to the extent permitted by law, associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, the Plan may recover any benefits they have advanced for any Injury or Illness through legal action against You and/or Your agent or attorney.
- If the Plan pays benefits for the treatment of an Illness or Injury, they will be entitled to have the amount of the benefits the Plan has paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which the Plan has provided benefits. This is true regardless of whether:

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

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

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

No-Fault Coverage

This provision applies when You incur health care expenses in connection with an Illness or Injury for which no-fault coverage is available. In that situation, benefits for otherwise Covered Services are excluded under this Contract to the extent Your expenses for services and supplies have been covered or have been accepted for coverage by a no-fault carrier.

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorist insurance. When the Plan uses the term motor vehicle insurance below, it includes medical expense coverage, personal injury protection coverage, uninsured motorist coverage, underinsured motorist coverage or any coverage similar to any of these coverages. Benefits for health care expenses are excluded under this Contract if You receive payments from uninsured motorist

coverage or underinsured motorist coverage for such expenses to the extent those payments exceed the amount necessary to fully compensate You, along with all other payments You receive to compensate You for Your Injuries, losses or damages, for those Injuries, losses or damages.

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

- If a claim for health care expenses arising out of a motor vehicle accident is filed with the Plan and motor vehicle insurance has not yet paid, the Plan may advance benefits for Covered Services as long as You agree in writing:
  - to give the Plan information about any motor vehicle insurance coverage which may be available to You; and
  - to otherwise secure the Plan's rights and Your rights.

- If the Plan has paid benefits before motor vehicle insurance has paid, the Plan is entitled to have the amount of the benefits the Plan has paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of You held in trust for the Plan. The amount of benefits the Plan is entitled to will never exceed the amount You receive from all insurance sources that fully compensates You for Your loss and the Plan will only seek to recover amounts You have received from other insurance sources to the extent those amounts exceed full compensation to You for Your Injuries, losses or damages.
- You may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the Right of Reimbursement and Subrogation Recovery provision apply. However, the Plan will not seek double reimbursement.

Workers' Compensation

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

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

- You must notify the Plan in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.

- If the entity providing workers' compensation coverage denies Your claims and You have filed an appeal, the Plan may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for the Plan according to the Right of Reimbursement and Subrogation Recovery provision.

Fees and Expenses

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

MAINTENANCE OF BENEFITS

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

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

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

Definitions

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

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

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

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

This Plan means the part of the Booklet providing the health care benefits to which the MOB provision applies and which may be reduced because of the benefits of Other Plans. Any other part of the Booklet providing health care benefits is separate from This Plan. A contract may apply one coordination of benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another 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 their employer's plan. If Your spouse incurs an expense covered under both plans and Your spouse's plan is the Primary Plan, This Plan, when paying as the Other Plan, would either pay the amount which when added to the Primary Plan's payment would

equal the amount This Plan would have paid had it been the Primary Plan or nothing if the Primary Plan's payment exceeded the amount This Plan would have paid had it been the Primary Plan.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

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

Appeal Process

This provision describes the process for submitting an appeal. You may submit an appeal, as detailed below, if You or Your Representative want a review of a claim denial or other action under the Plan. There are two levels of appeal, as well as additional voluntary appeal levels You may pursue. Situations that require a faster decision may qualify for an expedited appeal.

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

NOTE: For all appeals, written materials provided in support of the appeal that include others' medical or health records and other personal health information should not be submitted.

WHAT YOU MAY APPEAL

You may appeal an Adverse Benefit Determination. Appeals can be initiated through either written or verbal request using any of the following methods:

Method of Request	Contact Information
Fax	1-877-663-7526
Phone	Call the Claims Administrator at 1-800-376-7926
Mail	Attn: ASO Appeals and Grievances Regence BlueShield P.O. Box 1106 Lewiston, ID 83501-1106

Each level of appeal, except voluntary external review, must be pursued within 180 days of Your receipt of either the Claims Administrator's determination or the original adverse decision that You are appealing. If You don't appeal within this time period, You will not be able to pursue an appeal. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony. If You or Your treating Provider determine that Your health could be jeopardized by waiting for a decision under the regular appeal process, You or Your Provider may request an expedited appeal.

APPEAL DETERMINATION TIMING

Type of Appeal	When to Expect a Response
Internal appeal involving a Post-Service investigational issue	In writing, within 30 days of the Claims Administrator's receipt of the appeal.
Internal appeal involving all other issues, including a Pre-service preauthorization	In writing, within 15 days of the Claims Administrator's receipt of the appeal.
Expedited appeal	Verbal notice as soon as possible, but no later than 72 hours of receipt of the appeal, followed by written notice mailed to You within 3 calendar days of the verbal notice.
Voluntary external appeal by an Independent Review Organization (IRO)	In writing, within 45 days after the IRO receives the request.
Voluntary expedited appeal by an Independent Review Organization (IRO)	Verbal notice as soon as possible, but no later than 72 hours of the IRO's receipt of the appeal, followed by written notice within 48 hours of the verbal notice.

INTERNAL APPEALS

There are two levels of internal appeal reviewed by an employee(s) of the Claims Administrator who was not involved in the initial decision that You are appealing.

First-Level Internal Appeals

First-level appeals are reviewed by an employee(s) of the Claims Administrator who was 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.

Second-Level Internal Appeals

Second-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial or the first-level decision.

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO)

A voluntary appeal to an IRO is available 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 are 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.

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. 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.

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

EXPEDITED APPEALS

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

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

First-Level Expedited Appeal

The first-level expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. First-level expedited appeals are reviewed by the Claims Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination.

Voluntary External Expedited 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 external expedited appeal to an IRO. The criteria for a voluntary external expedited appeal to an IRO are the same as described above for a voluntary external appeal.

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

INFORMATION

If You have any questions about the appeal process, contact Customer Service at 1-800-376-7926 or write to Customer Service at the following address: Regence BlueShield, P.O. Box 1106, Lewiston, ID 83501-1106 or facsimile 1-877-663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including when based on a determination of a Participant's or Beneficiary's eligibility to participate in a Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational, or not Medically Necessary or appropriate. An Adverse Benefit Determination subject to review also includes a denial or rescission of coverage, and any request that the Claims Administrator reconsider a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits (i.e., contractual exclusions or limitations), including the admission to, or continued stay in, a health care facility.

Independent Review Organization (IRO) is an independent Physician review organization that acts as the decision-maker for voluntary external appeals and voluntary external expedited appeals and that is not controlled by the Claims Administrator.

Post-Service means a request to change an Adverse Benefit Determination for care or services that have been received, or any claim for benefits that is not considered Pre-Service.

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

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

Eligibility Appeals

Mail eligibility appeals to:

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

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

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

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

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

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

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

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

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

Eligibility and Enrollment

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

Coverage for You and Your enrolling eligible dependents will begin on the first day of the month following Your hire date, which is the first day You report to work. If Your hire date is the first calendar day of the month, coverage will begin on Your hire date.

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

Employees

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

Dependents

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

- The person to whom You are legally married (spouse).
- Your Washington state registered domestic partner as defined in the Washington State statute.
- Your (or Your spouse's or Your state-registered domestic partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's or Your state-registered domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your state-registered domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your state-registered domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your state-registered domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your state-registered domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
    - he or she is 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.

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

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

- You may not cover each other as dependents on the medical plan.
- You may both cover Your children on Your medical plans; however, with coordination of benefits, there are limited extra benefits.

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

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request to the Claims Administrator. Application for enrollment of a new child by birth, adoption or Placement for Adoption must be made within 60 days of the date of birth, adoption or Placement for Adoption if payment of additional premium is required to provide coverage for the child. Application for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates. For a new child by birth, the Effective Date is the date of birth. For a new child adopted or placed for adoption within 60 days of birth, the Effective Date is the date of birth, if any associated additional premium has been paid within 60 days of birth. The Effective Date for any other child by adoption or Placement for Adoption is the date of Placement for Adoption. For other newly eligible dependents, the Effective Date is the first day of the month following receipt of the application for enrollment.

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

SPECIAL ENROLLMENT

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

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

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

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

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

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

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

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

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

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

ANNUAL OPEN ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

RETIREE ELIGIBILITY

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

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

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

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

When Coverage Ends

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

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

AGREEMENT TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

Termination of Your Employment or You are No Longer Eligible

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

Nonpayment

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

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

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

Divorce or Annulment

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

Death of the Participant

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

Termination of Washington State Registered Domestic Partnership

If Your state-registered domestic partnership terminates after the Effective Date (including any change in status such that You and Your state-registered domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the state-registered domestic partner and the state-registered domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the month following the date of termination of the state-registered domestic partnership. You are required to provide notice of the termination of a state-registered domestic partnership within 30 days of its occurrence. This termination provision does not apply to any termination of state-registered domestic partnership that occurs as a matter of law because the parties to the state-registered domestic partnership enter into a marriage (including any entry into

marriage by virtue of an automatic conversion of the state-registered domestic partnership into a marriage).

Loss of Dependent Status

- Eligibility ends on the last day of the month in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the date in which an enrolled child is removed from placement due to disruption of placement before legal adoption.

OTHER CAUSES OF TERMINATION

Claimants terminated for the following reason may be able to continue coverage under the Plan according to the continuation of coverage provisions.

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

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

FAMILY AND MEDICAL LEAVE

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

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

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

FAMILY AND MEDICAL LEAVE - OTHER

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

MILITARY LEAVE OF ABSENCE

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

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

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

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

For complete information regarding Your rights under USERRA, contact the Plan Sponsor.

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

A leave of absence without pay is defined as a leave of absence that is unpaid and is not eligible for coverage under any applicable Federal, Washington State, or King County family medical leave law. Examples of applicable laws include FMLA, KCFML, WFLA, WFCA (King County Code 3.12.250). A leave of absence is an employer-granted period off work made at Your request during which You are still considered to be employed and are carried on the Plan Sponsor's employment records. A leave can be granted for any reason acceptable to Your employer.

COBRA Continuation of Coverage

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

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce, the marriage is annulled, or Your state-registered domestic partnership is terminated;
- You become entitled to Medicare benefits; or
- Your Beneficiary loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Beneficiaries per certain conditions if You are retired and Your employer files for bankruptcy.)

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

General Rules

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

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

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

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

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms described in the Booklet and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice

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

Other Continuation Options

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

Availability of Other Coverage

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

Strike, Lockout or Other Labor Dispute

If Your compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, You and Your Beneficiaries may continue coverage under the Plan during the dispute for a period not exceeding six months, by making the necessary payments for Your coverage through the Plan Sponsor. This provision will not apply if You and Your Beneficiaries are eligible for COBRA.

If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full cost, including any part usually paid by the Plan Sponsor, directly to the union or trust that represents You. The union or trust must continue to pay the Claims Administrator the payments according to the Agreement. This six months of continued coverage is instead of and not in addition to any continuation of coverage provisions of the Plan.

General Provisions and Legal Notices

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

CHOICE OF FORUM

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

GOVERNING LAW AND DISCRETIONARY LANGUAGE

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

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator. Neither the Claims Administrator nor the Plan is responsible for the quality of health care You receive, except as provided by law. In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

NO WAIVER

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

NONASSIGNMENT

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

NOTICES

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

NOTICE OF PRIVACY PRACTICES

A Notice of Privacy Practices is available by calling Customer Service or visiting the Claims Administrator's website.

PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of the Claims Administrator. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Booklet. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Booklet.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

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

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

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

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

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

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

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

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

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

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

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

TAX TREATMENT

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

The following are definitions of important terms, other terms are defined where they are first used.

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

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

Allowed Amount means:

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

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

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

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.

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

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

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

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

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

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.

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

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

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

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 visits that are intended to cover room and board, building, electronic medical records systems, billing, and other administrative or operational expenses.

Family means a Participant and any Beneficiaries.

Gender Affirming Treatment means Medically Necessary Covered Services (to the extent such services are permitted under applicable law) provided by a Provider and prescribed in accordance with generally accepted standards of care to treat gender dysphoria.

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

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

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

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

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

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

Illness means a:

- congenital malformation that causes functional impairment;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

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

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

In-Network Provider means a contracted Provider that is in Your Provider Network who provides services and supplies to Claimants in accordance with the provisions of this coverage. Your Provider network is: UW Medicine and may include Affiliates of the Claims Administrator. In-Network also means a Provider outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program. Refer to the Out-of-Area Services Section for additional details.

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

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

- in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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

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

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

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

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

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

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

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

- general practice;
- family practice;
- internal medicine;
- pediatrics;
- geriatrics;
- OB/GYN and obstetrics;
- preventive medicine;
- adult medicine; or

- women's health care practitioner.

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

Selection of a particular Provider to coordinate referrals or to receive primary care services is not required. You may change the Provider of Your care (including primary care) at any time by consulting a different Provider. If the Claims Administrator terminates the contract of Your Primary Care Provider without cause, the Claims Administrator will continue to cover Your Primary Care Provider, on the same terms, for a least 90 days following notice of termination.

Provider means:

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

Regence refers to Regence BlueShield.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

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

Service Area means King County in the state of Washington.

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.

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

Appendix: Value-Added Services

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

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

CONDITION MANAGER

If You are identified to participate, Condition Manager is a support and education program for people with chronic conditions. A care team will 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/or Practitioner and make smarter choices for health. To learn more, call 1-833-521-1411.

DIABETES MANAGEMENT

If You are identified to participate, the Diabetes Management program is an online program that has extensive support tools such as glucose tracking, live coaching, and emotional support to help You improve health and manage diabetes. To better track blood sugar levels and provide more focused support, You will be provided a glucose monitor.

DIABETES PREVENTION

The Diabetes Prevention program is an online program that has extensive support tools such as weight tracking, live coaching, online lessons of diabetes prevention-specific curriculum, and emotional support to help You track five key healthy behaviors (weight, food, mood, steps, and exercise) and prevent diabetes. To provide more focused support, You will be provided a weight scale.

HYPERTENSION MANAGEMENT

For members enrolled in the Diabetes Management program, the Hypertension Management program is an online program that has extensive support tools such as food and activity tracking, live coaching, and medication optimization support to help You improve health and manage hypertension. To better track blood pressure levels and provide more focused support, You will be provided a blood pressure monitor.

NURSE ADVICE

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

REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning up to $25 in gift cards for completion of well-being activities such as an online health risk assessment;
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

2026 Prescription Drug Benefit for KingCare Plan

- Your Prescription Medication Benefits Administered By Ventegra
- Overview of Prescription Drug Benefit
    - Summary of Member Cost Sharing

- Where to Purchase Prescription Drugs
    - Retail Pharmacy Network
    - Mail Order Service
    - Specialty Pharmacy Service

- How the Prescription Drug Benefit is Managed
    - Covered Drugs
    - Drug Formulary
    - Generic Drugs
    - Therapeutic Equivalency
    - Prior Authorization
    - Medical Necessity
    - Quantity Limits
    - Step Therapy
    - Ventegra Specialty Drug Inclusion Program
    - Benefits Preservation Program

- Expenses Not Covered
    - General Exclusions

- Paper Claims for Direct Member Reimbursement

- Prescription Drugs Appeals Process

Your Prescription Medication Benefits Administered By Ventegra

Your prescription medication coverage is administered through Ventegra. Ventegra is a separate company that provides pharmacy benefit management services and isn't affiliated with Regence BlueShield. Regence BlueShield assumes no liability for the accuracy of your prescription drug benefits information.

Overview of Prescription Drug Benefit

Your prescription drug coverage is provided through separate agreement(s) between King County and Ventegra. When you enroll in the KingCare medical plan, you will automatically receive your prescription drug coverage under the medical plan through Ventegra, the plan's prescription program vendor. The prescription drug coverage under the medical plan is referred to herein as the "Plan". This benefit booklet summarizes the key terms of the prescription drug coverage and is incorporated into the Summary Plan Description for King County Select Medical Plan. Except as specifically set forth in this Prescription Drug Program, the provisions of the King County Select Medical Plan also apply to the prescription drug coverage described herein.

If you have questions about your prescription benefit, call Ventegra at 1-844-571-2982.

Your prescription drug program benefit year is from 01/01/2026 to 12/31/2026.

Deductible and Annual Maximum Out-of-Pocket

Annual Deductible	$0
Annual Maximum Out Of Pocket (MOOP)	$1500 per individual $3000 per family

(continued next page)

KingCare Select Member Copays

ACA Preventive Drugs	$0
30-Day Supply Options	
Tier 1 (Generic Drug)	$5
Tier 2 (Preferred Drug)	$25
Tier 3 (Non-Preferred Drug)	$75
Tier 4 (Preferred Specialty Drug)	$25
Tier 5 (Non-Preferred Specialty Drug)	$75
90-Day Supply Options	
Tier 1 (Generic Drug)	$10
Tier 2 (Preferred Drug)	$50
Tier 3 (Non-Preferred Drug)	$150

Note: You pay the difference in cost between the brand and generic drug cost plus the generic co-pay, if generic equivalent is available. The difference in cost will not apply toward your deductible, if any, or out-of-pocket maximums.

Tier 4 and 5: Specialty Drugs	Members are required to fill specialty drug prescriptions through Costco Specialty Pharmacy. Specialty drugs are filled for 30 days supply ONLY.

Prior authorization is required on all non-formulary and specialty drugs, as discussed below in the "Prior Authorization" section.

Where to Purchase Prescription Drugs

Retail Pharmacy Network (30 to 91-day supply of medication option)

The Ventegra National Pharmacy Network includes major chains and independent pharmacies. You can check if your preferred pharmacy is in network by (1) presenting your Ventegra member ID card at the pharmacy, (2) checking the Ventegra Pharmacy Network directory at kingcounty.myVentegra.org or (3) by calling Ventegra at 1-844-571-2982.

Free Glucometer at network pharmacies: Members who use a glucometer can receive a free Accu-Check glucometer free of charge through your benefits at Ventegra network retail pharmacies. Take your prescription for an ACCU-CHEK meter to your local retail pharmacy with your Ventegra ID card.

Mail Service Pharmacy Network (91-day supply of medication option)

Your mail service pharmacy network is the following:

- Costco Pharmacy Mail Order (membership is not required to use Costco Mail Order). Set up your online account at **rx.coscto.com** or call 1-800-607-6861 for assistance.
- Customer Service hours: Mon.-Fri.: 5:00 AM – 7:00 PM PT and Sat. 9:30-2:00 PM PT

The mail order option allows you or an eligible dependent to receive a larger quantity of a prescription and is generally useful for long-term or maintenance-type drugs.

Specialty Pharmacy Network (30-day supply of medication ONLY)

Your specialty pharmacy network is the following:

- Costco Specialty Pharmacy (a Costco membership is not required to use Costco Specialty Services). Contact them by calling 1-855-213-0070.
- Customer Services hours: Mon.-Thurs. 6:00 AM – 5:00 PM PT and Fri. 6:00 AM – 4:00 PM PT.

The specialty pharmacy provides prescription drugs for certain chronic conditions or difficult to treat health conditions, such as multiple sclerosis, hepatitis C, or rheumatoid arthritis. These medications often require special handling, preparation, refrigeration, special administration, or monitoring.

For more information about your specialty pharmacy benefit, call Ventegra at 1-844-571-2982. Prior authorization is required on all specialty drugs. It is mandatory by the Plan that certain specialty drugs, such as injectables, are provided through Costco Pharmacy Specialty Services.

Participants who submit prior authorization requests for specialty drugs and are approved to obtain them by Ventegra will be contacted directly by CostCo Pharmacy Specialty Services. If your prior authorization request is denied, you will receive a denial notice from Ventegra.

How the Prescription Drug Benefit is Managed

Covered Drugs

The Plan provides coverage for formulary listed federal legend drugs which are drug products bearing the legend, “Caution: Federal law prohibits dispensing without a prescription” and certain non-prescription items. For the Plan to cover a prescription, the prescribed item must meet the following requirements:

- It must be a prescription written by a licensed clinician and not have exceeded the accepted date range of validity;
- It must be approved by the Federal Food and Drug Administration (FDA);
- It must be dispensed by a licensed pharmacy; and
- It must not be listed as an exclusion under this Plan.

Unless otherwise excluded, covered prescription drugs include the following when ordered by an authorized prescriber (subject to any prior authorization and/or quantity limits applied by your prescription drug benefit):

Affordable Care Act (ACA) Preventative Drugs – this drug list is subject to change as ACA guidelines are updated or modified. ACA preventative drugs are covered at no expense to you.

Contraceptives - Non-injectable contraceptives (e.g., oral, transdermal, intravaginal) and emergency contraceptives (e.g., Plan B) are covered if prescribed by a clinician.

Formulary Diabetic Supplies - Insulin and diabetic supplies including syringes, needles, insulin injectable devices, blood test strips, lancets, and lancet devices.

NOTE: Alcohol swabs, blood glucose calibration solutions, urine tests and insulin pumps are not covered under the pharmacy plan.

Select Self-Administered Injectables – many select self-administered injectable drugs are used for certain chronic conditions or difficult to treat health conditions, such as multiple sclerosis, hepatitis C, or rheumatoid arthritis. These medications require prior authorization and often require special handling, preparation, refrigeration, special administration or monitoring.

NOTE: Allergens are not covered.

Serums, Toxoids & Vaccines as part of ACA requirements and if not being administered under the King County medical plan benefit.

Drug Formulary

The drug formulary is a list of medications covered by the Plan. This formulary reflects the current judgment of Ventegra’s Clinical Advisory Committee (the “CAC”), which consists of doctors, pharmacists, and medical experts.

The drug formulary is developed to ensure members receive the best care and protection possible in a cost-effective manner. As such, the formulary places the drugs that are lowest cost clinically effective generic drugs in Tier 1, clinically effective low-cost brands or higher priced generic drugs in tier 2, and effective but highest cost brand drugs in Tier 3. Preferred Specialty drugs are covered under Tier 4 and non-preferred specialty drugs are covered under tier 5. A drug formulary supports and maximizes the effectiveness of prescribing guidelines and protocols for therapy. As such, the development and maintenance of the formulary is necessarily an ongoing and dynamic process.

The formulary is a continually revised compilation of pharmaceuticals which reflects the current clinical judgment of the CAC as they evaluate, appraise, and select from available FDA-approved medications and dosage forms that are considered most useful in treating patients. The CAC considers published

scientific and clinical data, treatment guidelines, FDA-approved indications, plan utilization and cost in the selection process. The goal of the CAC is to make the formulary comprehensive, proactive, and easy to use.

You may access the current list of formulary drugs through the Ventegra member portal at kingcounty.myventegra.org.

Generic Drugs

A generic drug is identical, or bioequivalent, to a brand-name drug. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the brand-name drug. In most cases, generic drugs are covered under tier 1, which is the lowest cost tier for members.

The Food and Drug Administration (FDA) works with pharmaceutical companies to ensure drugs (both brand and generic) meet specific requirements for quality, strength, purity, and potency.

To gain FDA approval, a generic drug must 1) contain the same active ingredients, 2) be identical in strength, dosage form, and route of administration, 3) have the same use indications, 4) be bioequivalent to the brand-name drug, and 5) meet the same requirements for identity, strength, purity, and quality as the brand-name drug. Finally, generic drugs must be manufactured under the strict standards of the FDA's good manufacturing practice regulations.

Some generics are made by the same pharmaceutical firms that make the brand-name drugs. Others are made by pharmaceutical companies that specialize in manufacturing generics. In all cases, all prescription medications (whether brand or generic) must meet the same rigid federal standards for quality, strength, and purity.

While generics have the same active ingredient as the brand-name medication, the inactive ingredients may be different. Inactive ingredients are fillers that are added to the medication to give it a certain color or to make a tablet a certain size. For legal reasons, a generic drug differs from its trade-name counterpart in size, color, and shape. Generic medication can sometimes look very different from the original brand-name medication.

Sometimes generics are available but can't be freely substituted for the original drug because no standards for comparison have been established by the FDA. These products may be sold but are not considered equivalent and may be substituted only under the supervision of your clinician.

If you ever have a question, your doctor or pharmacist can explain which generic drugs are acceptable substitutes.

Therapeutic Equivalency

If you are prescribed a drug that is not on the formulary, talk to your clinician or pharmacist to see if there is a therapeutic equivalent drug on the formulary. A therapeutic equivalent drug or what is also called a therapeutic interchange can be expected to produce similar levels of clinical effectiveness, sound medical outcomes and in some cases may have lower out of pocket expenses for you.

Your prescribing clinician needs to approve the therapeutically equivalent drug before making this change. The pharmacist can also do this for you after speaking to your prescribing clinician and getting his/her approval.

Prior Authorization Process

To promote appropriate utilization, certain formulary drugs, including selected high-risk or high-cost medications, require prior authorization to be eligible for coverage under the Plan. In addition, non-formulary drugs are generally not covered by the Plan and, to the extent non-formulary drugs could be covered, the non-formulary drugs require prior authorization. The CAC has established prior authorization criteria for these formulary and non-formulary drugs and maintains a list of the drugs requiring prior authorization. The list of drugs requiring prior authorization is subject to change. To confirm if a drug is on the Plan's current list of drugs requiring prior authorization call Ventegra's Customer Care Team at 1-1-844-571-2982, or check your formulary list by logging into your Ventegra member portal at **kingcounty.myventegra.org**. The formulary is also available at www.ventegra.org/formularies/VentegraPremiumFormulary.pdf

For a member to receive coverage for a medication requiring prior authorization, the member's clinician (or authorized representative) should contact the Ventegra Customer Care Team at 1-844-571-2982 to obtain a prior authorization request form or visit https://www.ventegra.com/PriorAuthorization.aspx. Your clinician must submit the completed prior authorization request form and, depending on the medication, the clinician may also be required to submit (i) medical records; and (ii) additional documentation supporting the reason why the requested drug is medically necessary or why a formulary medication is not acceptable for the treatment of your disease state or medical condition. With respect to the documentation for item (ii), your clinician should include in his/her communication your diagnosis and previous therapies that have failed. The completed form and all required supporting documentation (as referenced in the "Prior Authorization" section above) must be filed with Ventegra at:

Fax: 855-336-6612

IMPORTANT NOTE: Medications are not covered by the Plan in the event of an incomplete prior authorization request or a failure to submit a prior authorization request when required by the Plan.

Ventegra will provide all documentation received from a claimant to the Ventegra designated pre-service claim reviewer who is a Doctor of Pharmacy and will review the claim under the Plan's terms and applicable prior authorization criteria.

The table below provides the timeframes for processing prior authorization requests, which vary based on the type of pre-service claim involved.

Specified Timelines for Prior Authorization Reviews

Type of Prior Authorization Review	**Decision Timeframe**
Non-Urgent (Standard) Pre-Service Claim	**15 days***
Urgent (Expedited) Pre-Service Claim	**72 hours****

* If additional information is required from you (or your clinician) for a non-urgent (standard) claim, you (and your clinician) will be notified within the 15-day period from the receipt of the claim the specific information needed, and you will have at least 45 days to provide the information. Once all required information has been received, the Plan will provide a determination within 15 days after the earlier of the Plan's receipt of the specified information or the end of the 45-day period given you to provide the information.

** If additional information is required from you (or your clinician), you (and your clinician) will be notified within 24 hours of receipt of the claim of the specific information needed, and you will have at least 48 hours to provide the information. Once all required information has been received, the Plan will provide a determination within 48 hours after the earlier of the Plan's receipt of the specified information or the end of the 48-hour period given you to provide the information. If the benefit determination is provided verbally, it will be followed in writing no later than 3 days after the oral notice.

For pre-service claims that name a specific claimant, medical condition, and service or supply for which approval is requested, and which is submitted to a representative of Ventegra responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

If you wish to appeal a denial of a prior authorization decision, please see the Appeals section.

Medical Necessity

A medically necessary drug is any drug that is necessary or appropriate to treat a condition, illness, disease or injury based on currently accepted standards of medical practice and not primarily for the convenience of the member, family or prescribing clinician. The fact that a drug is FDA approved or that a prescribing clinician orders, recommends, or approves a prescription drug does not automatically make the drug medically necessary.

Determination of medical necessity will be based on:

1. Drug is necessary or appropriate to treat a condition, illness, disease or injury based on currently accepted standards of medical practice AND
2. Drug meets Plan-wide acknowledged criteria, including but not limited to health plan criteria and benefit language AND
3. Drug is not primarily for the convenience of the patient, family or prescribing clinician AND one of the following:
    - Documented trial and failure of formulary and/or lower cost alternatives, when available, within the previous 120 days, and trial has been ≥ 90 days OR
    - Contraindication and/or intolerance to ALL other formulary drugs and/or lower cost alternative pertaining to patient's diagnosis, medical conditions or other drug therapy OR
    - Clinician evaluated, charted documentation detailing trial and failure of, or intolerance/adverse events to formulary and/or lower cost alternatives including explanation of why treatment with the specific non-formulary product is necessary.

4. Dispense as written (DAW) approval may be granted if the plan benefit allows and all the following are true:

    - Supporting clinical documentation from the prescriber shows trial and failure of multiple (if available) generic manufacturers of the requested brand product.
    - Supporting clinical documentation from the prescriber shows trial and failure with or contraindication to cost-effective within-class alternatives or cost-effective therapeutically superior or therapeutically equivalent alternatives to the requested brand product.
    - The DAW prescription requested is not a multi-source specialty brand product with available generic, therapeutic, or biosimilar alternatives.

- Existing formulary policy is met including but not limited to step therapy, clinical prior authorization (PA), and specialty inclusion criteria.

Dispense As Written (DAW) Copay

The DAW Copay applies when a generic equivalent is available, but the member purchases the brand version of the drug instead. In those instances, the member will be responsible for the generic co-pay plus the DAW Copay, which is the difference in cost between the brand and generic drug.

The DAW Copay will not apply toward your deductible, if any, or out-of-pocket maximums.

Quantity Limits

Quantity limits ensure that you do not receive a prescription for a quantity that exceeds recommended Plan limits. Limits are set because some drugs have the potential to be abused, misused, shared, or have a manufacturer's limit on the maximum dose. These limits have been reviewed by our clinical and medical staff, and the CAC.

The quantity limits are based on FDA-approved dosing schedules, current medical practices, evidence-based clinical guidelines, and peer-reviewed medical literature related to that drug. Drugs subject to quantity limits can be found on the drug formulary available at https://www.ventegra.com/formularies/VentegraPremiumFormulary.pdf or contact a Ventegra customer service representative at 1-844-571-2982 to determine specific coverage and/or inclusion of a medication in the dispensing limitations list, as the list is subject to change.

Step Therapy

Step Therapy is a program especially designed for people who take prescription drugs regularly to treat an ongoing medical condition. The program helps you get the prescription drugs you need, with safety, cost and—most importantly— your health in mind.

In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor approving and writing your prescriptions. The program usually starts with generic drugs in the "first step." These generics—rigorously tested and approved by the U.S. Food & Drug Administration (FDA)—allow you to begin or continue treatment with safe, effective drugs that are also affordable: Your copayment is usually the lowest with a first-step drug.

More expensive brand-name drugs are usually covered in the "second step," even though the generics covered have been proven to be effective in treating medical conditions. Your doctor is consulted for approval and writes your prescriptions based on the list of Step Therapy drugs covered by the formulary. If you cannot take a first step drug, your doctor can ask for a "prior authorization" review for a second step medication.

Specialty Drug Inclusion Program

Medications for specialty conditions and Orphan Diseases are not always covered by this Plan. To determine whether such medications are covered, this Plan utilizes the Ventegra's Specialty Inclusion Program ("VSI"), which looks at not only FDA approval of the medications, but also evaluates the safety and efficacy of the medications before approving the Specialty and Orphan Products for coverage under the Plan. Specialty and Orphan Products listed in the VSI are all subject to Prior Authorization Review and only those Products that are set forth in the VSI will be covered under the Plan. For purposes of this Plan, the following definitions shall apply:

- “Orphan Product” means a Product used to treat an Orphan Disease and set forth in Ventegra’s then current Specialty Inclusion Program.
- “Orphan Disease” means a rare disease that affects fewer than 200,000 patients in the United States.
- “Specialty Product” means a Product other than an Orphan Product that is set forth in Ventegra’s then current Specialty Inclusion Program.

Specialty and Orphan Products listed in the VSI are subject to cost-sharing requirements as described in your Summary of Drug Benefit Grid.

If you have any questions about the VSI used by the Plan or the administration of the VSI, you may contact Ventegra at 1-844-571-2982.

Benefit Preservation Program

King County PPO Medical Plans participates in a medication assistance program through the Benefits Preservation Program (BPP), which accesses funds available from drug manufacturers to lower your cost and the amount that King County pays. BPP determines whether your specialty medication is eligible for financial assistance. If it is, BPP will contact you to enroll in their medication assistance program, which could substantially lower your costs. Please note that if you take a specialty drug that is not included in the medication assistance program, your prescription will be subject to the applicable specialty medication copays. BPP will only contact you regarding this program if your specialty medication is eligible for this assistance.

Member cost-sharing amounts provided in the plan design refer to actual out-of-pocket amounts paid by the member. Any amounts paid through the medication assistance programs will NOT apply to the member's deductible or annual out-of-pocket limit.

EXPENSES NOT COVERED

Certain types of prescriptions are not covered under the Plan. They include, but are not limited to the following:

- Charges for the administration or injection of any drug except for pharmacy-administered vaccines.
- Blood, blood plasma products or biological sera.
- All products used for cosmetic purposes including, but not limited to, photo-age skin products like Renova or Avage, hair growth/hair loss products like Rogaine, Vaniqa or Propecia, injectable cosmetics like Botox, Juvederm or Restylane, depigmentation products like Alphaquin HP or Tri-Luma.
- Vitamins – Legend and OTC vitamins, including prenatal agents and fluoride products.
- Diagnostic, Testing & Imaging Supplies.
- Durable medical equipment including but not limited to respiratory nebulizers, peak flow meters, ostomy supplies.
- Excess refills where refills exceed the number of times specified by a Clinician or which are dispensed more than one (1) year from the date of the Clinician's prescription order.
- Experimental/Investigational Drugs & Non-Food & Drug Administration (FDA) Approved Drugs – Any prescription drug which is experimental/investigational in nature or any drug not approved by the FDA.
- Drugs prescribed for the treatment of sexual dysfunction such as intracavernous vasoactive injections, Muse, vacuum constriction devices, Addyi, or Vyleesi.
- Injectable erectile dysfunction drugs.
- Homeopathic drugs.
- Medical foods except for use in a PKU diagnosis. Some medical foods may be covered under your medical benefit. See the "Medical Foods" section in this Booklet.
- Medication costs which are recoverable under any worker's compensation or occupational disease law or any local, state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the member.
- Non-home use agents which are drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Clinician's office or setting other than home use.
- Non-prescription/non-legend drugs which is a drug that can be legally purchased without a written prescription. Formulary Insulins are covered when prescribed by a clinician.
- Non-prescription/non-legend drugs which is a drug that can legally be purchased without a written prescription. Formulary Insulins are covered when prescribed by a clinician.
- Over-The-Counter (OTC) equivalents that are identical to prescription drugs in active chemical ingredient, dosage form, strength and route of administration.
- Smoking cessation/Deterrent drugs unless covered under Affordable Care Act (ACA) and

prescribed by a clinician.

- Weight management drugs such as Saxenda, Contrave, Qsymia or Belviq.

- Any prescription for more than the retail days' supply or mail service days' supply allowed under the Plan limits, as described under the Quantity Limits section above.

- Drugs that require prior authorization, when authorization is not approved.

- Lost, stolen or damaged prescriptions (excludes controlled substances) that exceed once per 12 months

- Any drug or medication that is not on the covered prescription drug list (i.e., Formulary) unless prior authorization is submitted and approved.

- Non-sedating antihistamine medications are not covered on the Plan.

- Anti-acne medications are not covered when used for cosmetic purposes or when used for a non-FDA approved indication.

- Formulary Shield medications which include, but are not limited to, agents that have not been shown to have additional clinical value over formulary drugs. This list includes, but is not limited to, nonformulary combination drugs (drugs containing two or more unique FDA approved drugs).

Prescription Drug Benefit GENERAL EXCLUSIONS

The following are the Plan's general exclusions, which include but are not limited to the following:

Drugs in Testing Phases - Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges - Charges higher than the Usual, Customary and Reasonable fees for services or supplies provided.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and

- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and

- reliable evidence shows that the consensus among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities - Services furnished to the member in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments and for which the member has no legal obligation to pay.

NOTE: This exclusion does not apply to treatment of non-service-related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active-duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Late-Filed Claims for Prescription Drugs - Claims that are not filed with Ventegra for handling within the required time periods as outlined by the Plan's claims procedures**.**

Military Service - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a member is not required to pay or is not billed or would not have been billed in the absence of coverage under this Plan.

Other Coverage - Services or supplies for which a member is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States - Charges incurred outside of the United States if the member traveled to such a location for the primary purpose of obtaining such services or supplies unless pre-approval is obtained by the Health Plan.

Prior Coverages - Services or supplies for which the member is eligible for benefits under the terms of the document that this benefit document replaces.

Prior to Effective Date / After Termination Date - Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care - Any service rendered to a member by a relative (i.e., a spouse, or a parent, brother, sister, or child of the member or of the member's spouse) or anyone who customarily lives in the member's household.

Sales Tax, Etc. - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition such as depression.

Paper Claims for Direct Member Reimbursement

Usually, when you go to a pharmacy to have a prescription filled, your claim is automatically submitted to Ventegra and the pharmacy is paid directly. Occasionally, there may be situations where this does not occur and you need to pay for the full cost of the prescription out-of-pocket, such as if you forgot your ID card and the pharmacy did not call the Ventegra Customer Care Team to confirm coverage before accepting your payment for the prescription. When this happens, you may submit a post-service claim for direct member reimbursement (DMR) for review by submitting a fully complete DMR request form to Ventegra by one of the following methods:

Mail: Ventegra, Inc.
10400 Overland Road
Box #353
Boise, ID 83709

Phone: 855-867-0943

Email: reimbursements@ventegra.com

Ventegra will review your paper claim for payment. If coverage is denied, you'll receive notice within 30 days of Ventegra receiving the paper claim. All post-service claims must be received by the Plan within **6 months** of the date of incurring the expense. Claims that are file more than **6 months after the date of service** will not be covered by the Plan.

Prescription Drug Appeals Process

An appeal is a formal way of requesting a review and/or change in an adverse benefit determination that has been made on your prescription drug coverage. The Plan requires one level of appeal before the Plan's internal appeals are exhausted. Both you, the member, and the Plan are subject to the procedures, rights, and responsibilities stated within this Plan.

You or your authorized representative must file an appeal with Ventegra within 180 days of receipt of the denial notice of a prior authorization or a denied claim. Requests for appeal which do not comply with this requirement will not be considered.

To initiate an appeal, you must submit a fully completed Adverse Benefit Determination (ABD) review form and attach any necessary information to decide the appeal. You can obtain a copy of the ABD review form by contacting Ventegra at 877-867-0943.

In general, the following information will need to be provided:

- Full name of patient;
- Member ID;
- Phone number;
- The drug name for which benefit coverage has been denied;
- Description of why the claimant disagrees with the denial; and
- Any additional documentation (e.g. chart notes, labs, medication history) that was outlined as missing for the initial adverse benefit determination.

Appeals must be submitted to Ventegra using one of the following methods:

Fax: 855-336-6612

Email: priorauthorization@ventegra.com

Mail : Ventegra, Inc.
450 North Brand Boulevard Suite 600
Glendale, CA 91203

Ventegra will provide the submitted information to an appeals administrator who will provide a full and fair review. Ventegra will communicate the appeals administrator's determination in accordance with the timeline below.

Timeline for Appeals

Type of Adverse Benefit Determination	Appeal Response Timeline
Non-urgent (standard) pre-service adverse benefit determination	30 days from receipt of the request*
Urgent (expedited) pre-service adverse benefit determination	72 hours from receipt of the request**
Direct Member Reimbursement (paper claim) post-service adverse benefit determination	60 days from receipt of the request***

* If additional information is required from you (or your clinician), you (and your clinician) will be notified within the 15-day period from the receipt of the appeal the specific information needed, and you will have

at least 45 days to provide the information. Once all required information has been received, the Plan will provide a determination within 15 days after the earlier of the Plan's receipt of the specified information or the end of the 45-day period given you to provide the information.

** If additional information is required from you (or your clinician), you (and your clinician) will be notified within 24 hours of receipt of the appeal the specific information needed, and you will have at least 48 hours to provide the information. Once all required information has been received, the Plan will provide a determination within 48 hours after the earlier of the Plan's receipt of the specified information or the end of the 48-hour period given you to provide the information.

*** If additional information is required from you (or your clinician), you (and your clinician) will be notified within the 30-day period from the receipt of the appeal the specific information needed, and you will have at least 45 days to provide the information. Once all required information has been received, the Plan will provide a determination within 30 days after the earlier of the Plan's receipt of the specified information or the end of the 45-day period given you to provide the information.

Notification of Appeal Denials

If the appeal is denied, in whole or in part, Ventegra will provide written notification of the adverse benefit determination on appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

- Identification of the claim, including date of service, name of provider, claim amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the claimant as soon as feasible upon request.
- The specific reason or reasons for the adverse benefit determination, including the denial code(s) and corresponding meaning(s), and the Plan's standard, if any, used in denying the claim.
- Reference to the specific Plan provisions on which the adverse benefit determination is based.
- A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the claim.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the denied appeal was based on a medical necessity, experimental/investigational, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.
- A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

The Plan relies upon certain internal criteria in reviewing appeals and issuing adverse benefit determinations. The criteria are available at no charge to you (or your authorized representative) upon

request. You may (or your authorized representative) request a copy of the applicable criteria by sending a letter to the following address:

Ventegra, Inc.
450 North Brand Boulevard Suite 600
Glendale, CA 91203

Telephone: 877-895-7158

Fax: 855-336-6612

Email: priorauthorization@ventegra.com

Independent External Review

If your appeal is denied, you will be notified in writing that your claim is eligible for an external review, and you will be informed of the timeframes and the steps necessary to request an external review. You must complete the internal claims and appeals procedures before you can request a voluntary external review. In addition, external review is only available in certain circumstances as described below in the External Review Process section.

If you decide to seek external review, an independent review organization (IRO) will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document, including any applicable internal criteria utilized for the claim. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on all interested parties, including you and the Plan.

External Review Process

The external review process is available only where the final internal appeal is denied based on any of the following:

1. a medical judgment (which includes but is not limited to: Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit).
2. a determination that a treatment is experimental or investigational; or
3. a rescission of coverage.

If your final internal appeal is denied, you (or your authorized representative) may request further review by an independent review organization (IRO). This request for external review must be made, in writing, within 4 months of the date you are notified of final internal appeal and adverse benefit determination. This external review is voluntary, i.e., you are not required to undertake this external review before you may pursue civil action under Section 502(a) of ERISA.

To initiate an external review, you must submit a fully completed Adverse Benefit Determination (ABD) review form and attach any necessary information to decide the appeal. You can obtain a copy of the ABD review form by contacting Ventegra at 877-867-0943.

External review requests must be submitted to Ventegra using one of the following methods:

Ventegra, Inc.
450 North Brand Boulevard Suite 600
Glendale, CA 91203

Fax: 855-336-6612

Email: customercareteam@ventegra.com

Within 5 business days following the date of receipt of the external review request, Ventegra will complete a preliminary review of the request to determine whether:

1. the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

2. the adverse benefit determination or the final internal adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

3. the claimant has exhausted the Plan's internal appeal process; and

4. the claimant has provided all the information and forms required to process an external review.

Ventegra will notify the claimant within 1 business day of completion of its preliminary review if either:

1. The request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, or

2. the request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow the claimant to perfect the request for external review within the 4-month filing period, or within the 48-hour period following receipt of the notification, whichever is later.

If the request is complete and eligible, Ventegra will assign the request to an IRO. Assignment of IROs is made on a rotating basis to one of three contracted IROs. Once that assignment is made, the following procedure will apply:

1. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

2. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

3. Within 5 business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the final internal appeal adverse benefit determination. Failure by the Plan to timely provide the documents and

information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the final internal adverse benefit determination. Within 1 business day after making the decision, the IRO must notify the claimant and the Plan.

4. Upon receipt of any information submitted by the claimant, the assigned IRO must within 1 business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its final internal appeal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated because of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its final internal appeal adverse benefit determination and provide coverage or payment. Within 1 business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

5. The IRO will review all the information and documents that are timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:

   - the claimant's medical records;
   - the attending health care professional's recommendation;
   - reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating provider;
   - the terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
   - appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
   - any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
   - the opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available.

6. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Claim Administrator.

7. The assigned IRO's decision notice will contain:
   - a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
   - the date the IRO received the assignment to conduct the external review and the date of the IRO decision;

- the references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health Plan or to the claimant;
- a statement that judicial review may be available to the claimant; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review

Generally, a claimant must exhaust the Plan's claims and appeals procedures to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if either:

1. The claimant receives an adverse benefit determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeals procedures would seriously jeopardize the claimant's life, health, or ability to regain maximum function, and the claimant has filed a request for an expedited internal review.; or

2. The claimant receives a final internal appeal adverse benefit determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the final internal appeal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, Ventegra must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

For more information contact the Claims Administrator at 1-800-376-7926 or You can write to P.O. Box 1106, Lewiston, ID 83501-1106

regence.com