REGENCE GROUP DIRECT BOOKLET FOR:

[GROUP NAME]

Group Number: [Group Number]

Medical Plan

Regence BlueShield

Introduction

Regence BlueShield

1800 Ninth Avenue
Seattle, WA 98101

P.O. Box 30271
Salt Lake City, UT 84130-0271

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

This Booklet describes benefits effective **[{Month - spell out} dd, yyyy]**, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Enrolled Employee and Enrolled Dependents (except that in the eligibility and continuation of coverage sections, the terms "You" and "Your" mean the Enrolled Employee only). The terms "We," "Us" and "Our" refer to Regence BlueShield and the term "Group" means the organization whose employees may participate under this coverage. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

NON-GRANDFATHERED

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

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

CONTACT INFORMATION

Customer Service: 1 (888) 367-2112

And visit Our Web site at: [web link]

Using Your Regence Group Direct Booklet

YOUR PARTNER IN HEALTH CARE

Regence BlueShield is pleased that Your Group has chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. Thanks to the purchase of Regence Group Direct health care coverage, You have coverage that's comprehensive, affordable and provided by a partner You can trust in times when it matters most.

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

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

Regence Group Direct health care coverage also allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** You choose to see an In-Network Provider and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances beyond the Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** You choose to see an Out-of-Network Provider and Your out-of-pocket expenses will generally be higher than seeing an In-Network Provider. Also, choosing this provider option means You may be billed for balances beyond the Deductible, Copayment and/or Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Booklet, We indicate the Provider You may choose and Your payment amount for each provider option on the Schedule of Benefits included in the beginning of the Booklet. See the Definitions Section of this Booklet for a complete description of In-Network and Out-of-Network Providers. You can also go to [web link] for further Provider network information.

ADDITIONAL MEMBERSHIP ADVANTAGES

When Your Group purchased Regence Group Direct health care coverage**,** You were provided with more than just great coverage. You also acquired Regence membership, which offers additional valuable services. The advantages of Regence membership include access to 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 [web link] , powered by the Regence Engine, an interactive environment that can help You navigate Your way through health care decisions. These additional valuable services are a complement to the group health plan, but are not insurance.

- **Go to[web link] .** Have Your Member card handy to log on. Use the Web site to view recent claims, get health guidance and support, get access to local events, and use tools for annual planning. It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar.
- **Go to [web link] or [web link].** Here You can identify Participating Pharmacies, find alternatives to expensive medicines, learn about prescriptions for various Illnesses and even compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

GUIDANCE AND SERVICE ALONG THE WAY

This Booklet was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Regence Group Direct health care coverage and the rewards of Regence membership throughout this Booklet, some of which are highlighted here. We realize that You may still have some questions about Your Regence Group Direct health care coverage, so please contact Us if You do.

- **Learn more and receive answers about Your coverage or any other plan that We offer.** Just call 1 (888) 367-2112 to talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit Our Web site at: **[web link]** .
- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (800) 322-1737.
- **BlueCard® Program**. Learn how to have access to care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

Table of Contents

Understanding Your Benefits

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

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

MAXIMUM BENEFITS

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

OUT-OF-POCKET MAXIMUM

Members can meet the Out-of-Pocket Maximum by payments of Deductible, Copayments and/or Coinsurance as specifically indicated on the Schedule of Benefits. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. Benefits, Deductibles and Out-of-Pocket Maximums accrued under one level of benefits do not also accrue to the other level of benefits. Ambulance Services, Blood Bank, Detoxification, Emergency Room, Pediatric Dental Services and Prescription Medications will always apply toward the In-Network Out-of-Pocket Maximum amount regardless of whether the Provider of these services is In-Network or Out-of-Network. All Essential Benefits (ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services) will accrue to either the In-Network or Out-of-Network maximum according to whether You have received those services In-Network or Out-of-Network. 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 this Contract's Out-of-Pocket Maximum.

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

There are two Family Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when two or more Family Members' Deductibles, Copayments and/or Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount. One Member may not contribute more than the individual Out-of-Pocket Maximum amount.

COPAYMENTS

A Copayment means a fixed dollar amount that You must pay directly to a Provider of services or supplies, including medications, at the time the service or supply is furnished. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service, supply or medication. Refer to the Schedule of Benefits to understand what Copayments (if any) You are responsible for.

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)

Once You have satisfied any applicable Deductible and any applicable Copayment, We pay a percentage of the Allowed Amount for Covered Services You receive, up to the Maximum Benefit. When Our payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your

Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage We pay varies, depending on the kind of service or supply You received and who rendered it. Refer to the Schedule of Benefits to understand what Coinsurance amounts You are responsible for.

We do not reimburse Providers for charges above the Allowed Amount. However, an In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over Our payment level in addition to the Deductible, Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after a Member satisfies the Calendar Year Deductibles. There are two Calendar Year Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. Deductibles accrued under one level of benefits do not also accrue to the other level of benefits. A Member satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. We do not pay for services applied toward the Deductible. Refer to the Schedule of Benefits to see if a particular service is subject to the Deductible. Ambulance Services, Blood Bank, Detoxification, Emergency Room and certain Prescription Medications will apply toward the In-Network Deductible amount.

There are two Family Calendar Year Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Calendar Year Deductible is satisfied when two or more covered Family Members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. One Member may not contribute more than the individual Deductible amount. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW

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

Some benefits of this Contract have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Calendar Year. Those exceptions include teaching doses of Self-Administrable Injectable Medication and hospice respite care and are further detailed in the Medical Benefits section of this Booklet.

Medical Benefits

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

All covered benefits, including the following Essential Health Benefits, are explained in this Medical Benefits Section, are provided after satisfaction of the Deductible and any Copayment specified on the Schedule of Benefits, and are subject to the limitations, exclusions and provisions of this plan:

- Ambulatory patient services - See the Office Visits – Illness or Injury; Other Professional Services; Dental Hospitalization; Dialysis; Family Planning; Home Health Care; Hospice Care; Hospital Inpatient, Outpatient and Ambulatory Service Facility; Nutritional Counseling, and Urgent Care Center benefits for a description of covered benefits.
- Emergency services - See the Ambulance Services and Emergency Room (Including Professional Services) benefits for a description of covered benefits.
- Hospitalization - See the Dental Hospitalization; Dialysis; Hospital Inpatient, Outpatient and Ambulatory Service Facility; Skilled Nursing Facility (SNF) Care and Transplants benefits for a description of covered benefits.
- Maternity and newborn care - See the Office Visits – Illness or Injury; Other Professional Services; Hospital Inpatient, Outpatient and Ambulatory Service Facility; Maternity; and Newborn Care benefits for a description of covered benefits.
- Mental health and substance use disorder services, including behavioral health treatment - See the Acupuncture; Chemical Dependency Services; Detoxification; Hospital Inpatient, Outpatient and Ambulatory Service Facility; and Mental Health Services benefits for a description of covered benefits.
- Prescription drugs - See the Preventive Care and Immunizations and Prescription Medications benefits for a description of covered benefits.
- Rehabilitative and Habilitative services and devices - See the Durable Medical Equipment; Habilitative Services; Orthotics; Other Professional Services; Prosthetic Devices; and the Rehabilitation Services benefits for a description of covered benefits.
- Laboratory services - See the Other Professional Services and Blood Bank benefits for a description of covered benefits.
- Preventive and wellness services and chronic disease management - See the Other Professional Services and Preventive Care and Immunizations benefits for a description of covered benefits.
- Pediatric services including vision care - See the Pediatric Dental and Vision Services benefits for a description of covered benefits.

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

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
The Calendar Year Out-of-Pocket Maximum amounts for this plan are specified on the Schedule of Benefits.

COPAYMENTS AND COINSURANCE
Copayments and Coinsurance for each applicable benefit are specified on the Schedule of Benefits.

CALENDAR YEAR DEDUCTIBLES
The Calendar Year Deductible amounts for this plan are specified on the Schedule of Benefits.

PREVENTIVE CARE AND IMMUNIZATIONS
We cover preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, FDA-approved contraceptive devices and implants including the insertion and removal of those devices or implants, routine immunizations for adults and children as recommended by the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and routine health screenings. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco cessation. See the Prescription Medications benefit for a description of how to obtain Generic Medications. Coverage for all such services is provided only for preventive care as designated below.

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision of the Contract, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the USPSTF, the HRSA or by the CDC. In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit **[web link]** or contact Customer Service at 1 (888) 367-2112. NOTE: Covered Services that do not meet this criteria will be covered the same as any other Illness or Injury. In addition, covered expenses do not include immunizations if the Member receives them only for the purpose of travel, occupation or residence in a foreign country.

OFFICE VISITS – ILLNESS OR INJURY
We cover office visits for treatment of Illness or Injury. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (separate facility fees billed in conjunction with the office visit for example) are not considered an office visit under this provision. For example, We will pay for a surgical procedure performed in the office according to the Other Professional Services benefit.

OTHER PROFESSIONAL SERVICES
We cover services and supplies provided by a professional Provider subject to any specified limits as explained in the following paragraphs:

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

Professional Inpatient
We cover professional inpatient visits for Illness or Injury.

Radiology and Laboratory
We cover services for treatment of Illness or Injury, including genetic testing. This includes, but is not limited to, mammography and prostate screening services not covered under the Preventive Care and Immunizations benefit.

Diagnostic Procedures
We cover services for diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies, sleep studies and neurology/neuromuscular procedures.

Surgical Services
We cover surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist, including coverage of cochlear implants.

Therapeutic Injections
We cover therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit. Teaching doses (by which a Provider educates the Member to self-inject) are covered for this list of Self-Administrable Injectable Medications up to a limit of three doses per medication per Member Lifetime. We consider teaching doses that are applied toward the Deductible as benefits provided and apply them against the Maximum Benefit limit on these services.

ACUPUNCTURE
We cover acupuncture services provided by a professional Provider to a maximum of 12 visits per Member per Calendar Year. We consider visits for these services that are applied toward the Deductible as benefits provided and apply them against the Maximum Benefit limit on these services. (There are no visit limits for acupuncture to treat Chemical Dependency Conditions.)

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

BLOOD BANK
We cover the services and supplies of a blood bank.

CHEMICAL DEPENDENCY SERVICES
We cover Chemical Dependency Services for treatment of Chemical Dependency Conditions, including the following:

- acupuncture services (when provided for Chemical Dependency Conditions, these acupuncture services do not apply toward the overall acupuncture Maximum Benefit); and
- Prescription Medications that are prescribed and dispensed through a chemical dependency treatment facility (such as methadone).

Definitions
In addition to the definitions in the Definitions Section, the following definitions apply to this Chemical Dependency Services benefit:

Chemical Dependency 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. Chemical dependency 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. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

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

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

Exclusively for the purpose of this Chemical Dependency 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.

DENTAL HOSPITALIZATION

We cover inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an ambulatory surgical center or Hospital is necessary to safeguard Your health. Benefits are not available for the charges of a dentist or for services received in a dentist's office.

DETOXIFICATION

We cover Medically Necessary detoxification services for alcoholism and drug abuse as an Emergency Medical Condition and do not require pre-authorization or pre-notification. You may choose to see an In-Network or Out-of-Network Provider for the provision of detoxification services. See the Definitions Section of this Contract for a complete description of In-Network and Out-of-Network Providers. You can also go to **[web link]** for further Provider network information.

DIABETIC EDUCATION

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

DIABETES SUPPLIES AND EQUIPMENT

We cover supplies and equipment for the treatment of diabetes. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medications benefits for coverage details of such covered supplies and equipment.

DIALYSIS

We cover inpatient and outpatient services and supplies for dialysis. You may choose to see an In-Network or Out-of-Network Provider for the provision of dialysis services. See the Definitions Section of this Contract for a complete description of In-Network and Out-of-Network Providers. You can also go to **[web link]** for further Provider network information.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Member's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item. We also cover sales tax under this benefit for Durable Medical Equipment and mobility enhancing equipment, that is a Covered Service and when such equipment is not otherwise tax exempt.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

We cover emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized. See the Hospital Care benefit for coverage of inpatient Hospital admissions.

FAMILY PLANNING

We cover certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy under this benefit.

For coverage of prescription contraceptives, please see the Prescription Medications benefit. You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of women's contraceptives that are

specifically designated as preventive medications. For a list of such medications, please visit **[web link]** or **[web link]** or contact Customer Service at 1 (888) 367-2112.

For more information on preventive services for women, including HIV screening, HPV DNA testing, sterilization procedures, and certain patient education and counseling services, see the Preventive Care and Immunizations benefit of this Contract or for a list of covered preventive services, please visit **[web link]** or contact Customer Service at 1 (888) 367-2112.

HABILITATIVE SERVICES

We cover Medically Necessary inpatient and outpatient health care services, including speech therapy, occupational therapy, physical therapy and aural therapy, and devices approved by the United States Food and Drug Administration (FDA) that are designed to assist the Member in partially or fully developing, keeping and learning age appropriate skills and functioning, within the Member's environment or to compensate for the Member's progressive physical, cognitive and emotional illness. Chore services to assist with basic needs, vocational or custodial services are not classified as Habilitative Services and are not covered under this Contract. Inpatient services are limited to a maximum of 30 days per Member per Calendar Year. Outpatient services are limited to a maximum of 25 visits per Member per Calendar Year.

HOME HEALTH CARE

We cover home health care when provided by a licensed agency or facility for home health care to a maximum of 130 visits per Member per Calendar Year. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. We consider visits for these services that are applied toward the Deductible as benefits provided and apply them against the Maximum Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit.

HOSPICE CARE

We cover hospice care when provided by a licensed hospice care program. The only hospice limit is a maximum of 14 inpatient or outpatient respite days per Member Lifetime. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. Respite care: We cover respite care to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member. We consider respite days that are applied toward the Deductible as benefits provided and apply them against the Maximum Benefit limit on these services. Durable Medical Equipment is covered under this benefit when billed by a licensed hospice care program. For a definition of Durable Medical Equipment, see the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SERVICE FACILITY

We cover the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Service Facility for Injury and Illness (including services of staff providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. See the Emergency Room benefit for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

MATERNITY CARE

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Members (including eligible dependents of dependents who have enrolled under this Contract). There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy for all female Members.

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

MEDICAL FOODS (PKU)

We cover medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

MENTAL HEALTH SERVICES

We cover Mental Health Services for treatment of Mental Health Conditions.

Definitions

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

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

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

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

NEURODEVELOPMENTAL THERAPY

We cover inpatient and outpatient neurodevelopmental therapy services. Outpatient neurodevelopmental therapy services are limited to a maximum of 25 outpatient visits per Member per Calendar Year. To be covered, such services must be to restore and improve function for a Member age six and under. Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Member's condition would result without the service. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

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

NUTRITIONAL COUNSELING

We cover nutritional counseling for all conditions, including obesity, not subject to any specific visit limitation.

ORTHOTIC DEVICES

We cover benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. We may elect to provide benefits for a less costly alternative item. We do not cover off-the-shelf shoe inserts and orthopedic shoes.

PEDIATRIC DENTAL

We cover pediatric Dental Services for Members under the age of 19. Please note that the BlueCard Program detailed in the Contract and Claims Administration Section does not apply to dental benefits provided under this Pediatric Dental benefit. We will pay benefits under this Pediatric Dental benefit, not any other provision of this Booklet, if a service or supply is covered under both.

Preventive And Diagnostic Dental Services

We cover the following preventive and diagnostic Dental Services:

- Bitewing x-rays, limited to two sets per Member per Calendar Year for a total of four bitewing x-rays per Calendar Year.
- Cephalometric films, limited to once in a two-year period.
- Complete intra-oral mouth x-rays, limited to one in a three-year period.
- Diagnostic casts when Dentally Appropriate.
- Limited oral evaluations to evaluate the Member for a specific dental problem or oral health complaint, dental emergency or referral for other treatment.
- Limited visual oral assessments or screenings, limited to two per Member per Calendar Year, not performed in conjunction with other clinical oral evaluation services.
- Occlusal intraoral x-rays, limited to once in a two-year period.
- Oral hygiene instruction, limited to two times per Calendar Year for ages eight and under, if not billed on the same day as a cleaning.
- Periapical x-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment.
- Photographic images (oral and facial) when Dentally Appropriate.
- Periodic and comprehensive oral examinations, limited to two per Member per Calendar Year, beginning before one year of age.
- Problem focused oral examinations.
- Panoramic mouth x-rays, limited to one in a three-year period.
- Cleanings, limited to two per Member per Calendar Year.
- Sealants, limited to permanent bicuspids and molars.
- Space maintainers (fixed unilateral or fixed bilateral) for Members 12 years of age and under, subject to the following limits:

    - re-cementation of space maintainers is covered for Members 12 years of age and under;
    - removal of space maintainers; and
    - replacement space maintainers are covered when Dentally Appropriate.

- Topical fluoride application: for Members ages six and under, limited to three treatments per Member per Calendar Year; for Members ages seven and older, limited to two treatments per Member per Calendar Year; and limited to three treatments per Member per Calendar Year during orthodontic treatment. Additional topical fluoride applications are covered when Dentally Appropriate.

Basic Dental Services

We cover the following basic Dental Services:

- Complex oral surgery procedures including surgical extractions of teeth, impactions, alveoloplasty, vestibuloplasty and residual root removal. Frenulectomy and frenuloplasty care is covered for Members ages six and under.
- Emergency treatment for pain relief.
- Endodontic services consisting of:

    - apexification for apical closures of anterior permanent teeth;
    - apicoectomy;
    - debridement;
    - direct pulp capping;
    - pulpal therapy;

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

- Endodontic benefits will **not** be provided for:

  - indirect pulp capping.

- Fillings consisting of composite and amalgam restorations, limited to the following:

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

- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Member's health (for example, a child under eight years of age). Other services related to general anesthesia or intravenous sedation are covered as follows:

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

- Periodontal services consisting of:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Member per quadrant in a five-year period;
  - debridement limited to once per Member in a three-year period;
  - gingivectomy and gingivoplasty limited to once per Member per quadrant in a three-year period;
  - periodontal maintenance limited to once per quadrant in a Calendar Year for Members 13 years of age and older; and
  - scaling and root planing limited to once per Member per quadrant in a two-year period for Members 13 years of age and older.

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

Major Dental Services

We cover the following major Dental Services:

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.
- Behavior management.
- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement.
- Crowns and crown build-ups, limited to the following:

  - an indirect crown in a five-year period, per tooth, for permanent anterior teeth for Members 12 years of age and older;
  - cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;

  - core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;
  - recementations of permanent indirect crowns for Members 12 years of age and older;
  - stainless steel crowns for primary posterior teeth once in a three-year period; and
  - stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17 and 32) once in a three-year period.

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

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

- Home visits, including extended care facility calls, limited to two calls per facility per provider.
- Medically Necessary orthodontic services for Members with malocclusions associated with:

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

- Occlusal guards for Members age 12 and older.
- Post-surgical complications.
- Repair of crowns is limited to one per tooth per Member Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Member Lifetime.

EXCLUSIONS

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Pediatric Dental benefit:

Aesthetic Dental Procedures

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

Antimicrobial Agents

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

Collection of Cultures and Specimens

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies

Except for Dentally Appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Injury or Illness, We do not cover cosmetic and/or reconstructive services and supplies.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).

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

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

Duplicate X-Rays

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

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

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

Interim Partial or Complete Dentures

Medications and Supplies
Except as specifically provided in this Pediatric Dental benefit, We do not cover charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Occlusal Treatment
Except as specifically provided in this Pediatric Dental benefit, We do not cover services and supplies provided in connection with dental occlusion, including occlusal analysis and adjustments.

Oral Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Orthodontic Dental Services
Except as specifically provided in this Pediatric Dental benefit, We do not cover services and supplies provided in connection with orthodontics, including the following services:

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

Precision Attachments

Provisional Splinting

Replacements
Except as specifically provided under this Pediatric Dental benefit, We do not cover services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

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

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

Services Performed in a Laboratory

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

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

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided in connection with temporomandibular joint (TMJ) disorder.

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

Veneers

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Pediatric Dental benefit:

Allowed Amount means:

- With respect to In-Network Dentists, the amount In-Network Dentists have contractually agreed to accept as full payment for Covered Services.
- With respect to Out-of-Network Dentists, reasonable charges for Covered Services as determined by Us.

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

Covered Service means those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues and are Dentally Appropriate. These services must be performed by a Dentist or other Provider practicing within the scope of his or her license.

Dentally Appropriate means a dental service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and determined by Us (or Our designee) to be all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;

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

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE UNDER THIS CONTRACT.

Dentist means an individual who is licensed to practice dentistry (including a doctor of medical dentistry, doctor of dental surgery or a denturist). A Dentist also means a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties.

In-Network Dentist means a Dentist who has an effective participating contract with Us to provide services and supplies to Members in accordance with the provisions of this Contract.

Out-of-Network Dentist means a Dentist who does not have an effective participating contract with Us to provide services and supplies to Members, or any other Dentist that does not meet the definition of an In-Network Dentist under this Contract.

GENERAL INFORMATION

In-Network Dentist Claims

You must present Your member card when obtaining Covered Services from an In-Network Dentist. You must also furnish any additional information requested. The In-Network Dentist will furnish Us with the forms and information needed to process Your claim.

In-Network Dentist Reimbursement

An In-Network Dentist will be paid directly for Covered Services. In-Network Dentists have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Coinsurance. An In-Network Dentist may require You to pay Your share at the time You receive care or treatment.

Out-of-Network Dentist Claims

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

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

Out-of-Network Dentist Reimbursement

If You use an Out-of-Network Dentist for Covered Services, a check will be sent to the Out-of-Network Dentist, unless You already paid the Out-of-Network Dentist and We are made aware of that, in which case the check will be sent to You.

Out-of-Network Dentists have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Out-of-Network Dentist and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For Out-of-Network Dentists, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

Freedom of Choice of Dentist

Nothing contained in this Contract is designed to restrict You in selecting the Dentist of Your choice for dental care or treatment.

PEDIATRIC VISION

We cover pediatric vision care for Members under the age of 19. Covered Services are those services required for the diagnosis or correction of visual acuity and must be rendered by a Physician or optometrist practicing within the scope of his or her license.

All terms and conditions of the Contract apply to this Pediatric Vision benefit, except as otherwise noted. However, the BlueCard Program detailed in the Contract and Claims Administration Section does not apply to vision hardware benefits provided under this Pediatric Vision benefit. We will pay benefits under this Pediatric Vision benefit, not any other provision of the Contract, if a service or supply is covered under both.

Pediatric Vision Examination

We cover one routine vision examination per Member per Calendar Year, including dilation and with refraction.

Pediatric Vision Hardware

We cover hardware including frames, contacts (in lieu of glasses) and all lenses and tints. Frames are covered to a maximum of one frame per Member per Calendar Year. Spectacle lenses are covered to a maximum of one pair per Member per Calendar Year, including polycarbonate lenses and scratch resistant coating. Low vision optical devices, aids, low vision services including comprehensive low vision evaluations and follow-up care are covered. Also covered are high power spectacles, magnifiers and telescopes. Two pairs of glasses may not be ordered in lieu of bifocals. Separate charges for fittings will not be covered under the Contract.

PRESCRIPTION MEDICATIONS

We cover Prescription Medications listed under the Essential Formulary on Our Web site. To view this Essential Formulary visit Our Web site at **[web link]**.

Essential Formulary Changes

Any removal of a Prescription Medication from Our Essential Formulary will be posted at **[web link]** thirty days prior to the effective date of that change unless the removal is done on an emergency basis or if an equivalent Generic Medication becomes available without prior notice. In the case of an emergency removal, the change will be posted as soon as practicable.

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

Substitution Process

Non-formulary medications are not routinely covered under your Prescription Medications benefit; however, Brand-Name Medication not on the Essential Formulary may be covered under certain circumstances. Non-formulary means those self-administered Prescription Medications not listed in the Essential Formulary for Your plan at **[web link]**.

To request coverage for a Brand-Name Medication not on the Essential Formulary, You or Your Provider will need to request Preauthorization so that We can determine that a Brand-Name Medication not on the Essential Formulary is Medically Necessary. Your Brand-Name Medication not on the Essential Formulary may be considered Medically Necessary if:

- You are not able to tolerate covered Brand-Name Medication on the Essential Formulary; or
- Your Provider determines that the Brand-Name Medication on the Essential Formulary is not therapeutically efficacious for treating Your covered condition; or
- Your Provider determines that a dosage required for efficacious treatment of Your covered condition differs from the Brand-Name Medication on the Essential Formulary dosage limitation.

The specific medication policy criteria to determine if a Brand-Name Medication not on the Essential Formulary is Medically Necessary are available at **[web link]**. You or Your Provider may request prior authorization by calling Customer Service at 1 (888) 367-2112, or by completing and submitting the form available at **[web link]**.

The substitution process may also be used to substitute a covered Brand-Name Medication for another drug on the Essential Formulary if:

- You do not tolerate the covered formulary drug: or
- Your provider determines that the covered formulary drug is not therapeutically efficacious for treating Your covered condition.

Once Preauthorization has been approved, the Brand-Name Medication will be available for coverage at the substituted Medication Copayment and/or Coinsurance level determined by Your benefit.

Brand-Name Prescription Medication Instead of Generic

If an equivalent Generic Medication is available and You choose to fill a Prescription Order with a Brand-Name Medication, even if the prescribing Provider specifies that the Brand-Name Medication must be dispensed, You will be responsible for paying the difference in cost (which does not count toward Your Deductible or Out-of-Pocket Maximum). The difference is calculated at the time of purchase based upon the difference in price between the equivalent Generic Medication and the applicable Brand-Name Medication, in addition to the Copayment and/or Coinsurance (as applicable). You will not be responsible for the difference in cost if Your Brand-Name Medication has been preauthorized through the Substitution Process. You will only be charged the discounted rate for a prescribed Brand-Name Medication if You have completed the substitution process outlined in the Substitution Process section above and Preauthorization has been approved.

Covered Prescription Medications

Benefits under this Prescription Medications provision are available for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- Foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States, except as may be provided under the Investigational definition in the Definitions Section of this Contract;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- all FDA-approved women's contraception methods as recommended by the HRSA;
- immunizations for adults and children according to, and as recommended by, the CDC;
- Specialty Medications;
- Self-Administrable Cancer Chemotherapy Medication;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications); and
- Growth hormones (if preauthorized).

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. For a list of such medications, please visit **[web link]** or contact Customer Service at 1 (888) 367-2112.

Certain prescribed brand-name insulin drugs are made available at the Generic Medication payment level. If those designated insulin drugs are ineffective, other insulin drugs may be made available to You through our substitution process at the Generic Medication payment level. Please visit **[web link]** or **[web link]** or contact Customer Service at 1 (888) 367-2112 for more information.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. There are more than 1,200 Participating Pharmacies in Our Washington State network from which to choose.

Your Member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Member of Regence BlueShield, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find a list of Participating Pharmacies and a Pharmacy locator on Our pharmacy services Web site at **[web link]** or **[web link]** or by contacting Customer Service at 1 (888) 367-2112. Medications dispensed to You while You are inpatient in a Hospital, Skilled Nursing Facility, or other facility, that is not a Participating Pharmacy, will be provided under the applicable benefit.

Claims Submitted Electronically

You must present Your Member card at a Participating Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Coinsurance at the time of purchase.

Claims Not Submitted Electronically

When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to Us. We will reimburse You based on the Covered Prescription Medication Expense, less the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. We will send payment directly to You.

Mail-Order

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

To buy Prescription Medication through the mail, simply send all of the following items to a Mail-Order Supplier at the address shown on the prescription mail-order form available on Our pharmacy services Web site at **[web link]** or **[web link]** or from Your Group (which also includes refill instructions):

- a completed prescription mail-order form;
- any Deductible, Copayment and/or Coinsurance; and
- the original Prescription Order.

Member's Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective Pharmacy services, and to guarantee Your right to know what medications are covered and what coverage limitations are under the Contract. If You would like more information about the medication coverage policies under the Contract, or if You have a question or a concern about Pharmacy benefits, please contact Us at 1 (888) 367-2112.

If You would like to know more about Your rights under the law, or if You think anything You have received from Us may not conform to the terms of the Contract, You may contact the Washington State Office of Insurance Commissioner at 1 (800) 562-6900. If You have a concern about the Pharmacists or Pharmacies serving You, please call the State Department of Health at 1 (360) 236-4825.

Preauthorization

Preauthorization may be required so that We can determine that a Prescription Medication is Medically Necessary before it is dispensed. We publish a list of those medications that currently require preauthorization. You can see the list on Our pharmacy services Web site at **[web link]** or **[web link]** or contact Customer Service at 1 (888) 367-2112. In addition, We notify Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

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

Limitations

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

- **Maximum 30-Day or Greater Supply Limit**
  - **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 30-day supply. The Copayment and/or Coinsurance for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
  - **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Pharmacy, is a 30-day supply.
  - **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 30-day supply as indicated above.
  - **Participating Pharmacy and 30-Day Supply.** Except as specifically provided below, a 30-day supply is the largest allowable quantity of a Prescription Medication that You may purchase from a Participating Pharmacy and for which a single claim may be submitted. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities.
  - **Participating Pharmacy and 90-Day Supply.** The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Participating Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Copayment and/or Coinsurance is based on each 30-day supply within that multiple-month supply.

- **Maximum Quantity Limit**
  For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Member card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by checking Our pharmacy services Web site at **[web link]** or **[web link]** or contacting Customer Service at 1 (888) 367-2112. We do not cover any amount over the established maximum quantity, except if We determine the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

- **Refills**
  We will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible or Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at Our discretion on a case-by-case basis. You may request an exception by calling Customer Service at 1 (888) 367-2112.

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

Exclusions

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medications benefit:

Biological Sera, Blood or Blood Plasma

Brand-Name Medications not on the Essential Formulary or Provided Through the Substitution Process

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

Foreign Prescription Medications: We do not cover foreign Prescription Medications for non-Emergency Medical Conditions while traveling outside the United States.

Non-Self-Administrable Medications

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

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

Prescription Medications Not Dispensed by a Participating Pharmacy

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

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

Professional Charges for Administration of Any Medication

Travel Immunizations Received for Purposes of Travel, Occupation or Residence in a Foreign Country

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medications benefit:

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

Category 1 Brand-Name Medication means all preferred brand medications that are not a Specialty Medication.

Category 2 Brand-Name Medication means all less preferred (non-specialty) brand medications listed on the Medicare Part D formulary.

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

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

Essential Formulary means Our list of selected Prescription Medications. We established Our Essential Formulary and We review and update it routinely. It is available on Our Web site at **[web link]** or **[web link]** or by calling Customer Service at 1 (888) 367-2112. Medications are reviewed and selected for inclusion in Our Essential Formulary by an outside committee of providers, including Physicians and Pharmacists.

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

Mail-Order Supplier means a mail-order Pharmacy with which We have contracted for mail-order services.

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy means either a Pharmacy with which We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating Pharmacies have the capability of submitting claims electronically.

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

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

Self-Administrable Prescription Medications (also Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication) means, a Prescription Medication (including, for Self-Administrable Cancer Chemotherapy Medication, oral Prescription Medication used to kill or slow the growth of cancerous cells), determined by Us, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what We

consider Self-Administrable Medications, We refer to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that We consider a relevant and reliable indication of safety and acceptability. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Medications means medications used for patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit Our pharmacy services Web site at **[web link]** or **[web link]** or contact Customer Service at 1 (888) 367-2112.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, please visit Our pharmacy services Web site at **[web link]** or **[web link]** or contact Customer Service at 1 (888) 367-2112.

PROSTHETIC DEVICES

We cover prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, mastectomy bras only for Members who have had a mastectomy, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital inpatient care or Hospital outpatient and Ambulatory Service Facility care). We will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

RECONSTRUCTIVE SERVICES AND SUPPLIES

We cover inpatient and outpatient services for treatment of reconstructive services and supplies:

- to treat a congenital anomaly;
- to restore a physical bodily function lost as a result of Injury or Illness; 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 of this Contract.

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

We cover inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness as specified on the Schedule of Benefits. Inpatient services are limited to a maximum of 30 days per Member per Calendar Year. Outpatient services are limited to a maximum of 25 visits per Member per Calendar Year. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

SKILLED NURSING FACILITY (SNF) CARE

We cover the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability to a maximum of 60 inpatient days per Member per Calendar Year. 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. We consider days for these services that are applied toward the Deductible as benefits provided and apply them against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward the Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

We cover spinal manipulations performed by any Provider to a maximum of ten spinal manipulations per Member per Calendar Year. We consider manipulations that are applied toward the Deductible as benefits provided and apply them against the Maximum Benefit limit on these services. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits.

TELEMEDICINE

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

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

We cover inpatient and outpatient services for treatment of temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:

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

"Covered 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 Investigational or primarily for Cosmetic purposes.

TRANSPLANTS

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

Donor Organ Benefits

We cover donor organ procurement costs if the recipient is covered for the transplant under this plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs that We determine.

Transplant Waiting Period

You will not be eligible for any benefits related to a transplant until You have been continuously covered under this or any previous medical plan for 90 days.

We will reduce the duration of the transplant waiting period by the amount of Your combined periods of creditable coverages, as defined below. For crediting to apply for more than one creditable coverage, there must have been no break in creditable coverage greater than 63 days immediately preceding Your enrollment date of coverage under the Contract or between any two successive creditable coverages for which You seek credit. Creditable coverage also includes one immediately previous and otherwise creditable coverage that terminated in the period beginning 90 days and ending 64 days before the date of application for coverage under the Contract. Creditable coverage may still be in force at the time credit for it is sought on this coverage.

Creditable coverage means any of the following: group coverage (including self-funded plans); individual insurance coverage; S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high-risk pool coverage; Federal Employee Health Benefit Plan coverage; and public health plans (including foreign government and US government plans).

Creditable coverage is determined separately for each Member.

The following periods do not count in the calculation of the length of a break in coverage:

- days in a waiting period for eligibility for coverage under the Contract; and
- for an individual who elects COBRA continuation coverage during the second election period offered under the Trade Act of 2002, days between the loss of coverage and the first day of that second election period.

You have the right to demonstrate the existence of creditable coverage by providing Us with one or more certificates of creditable coverage from a prior group or individual plan or with other documentation. You may obtain a certificate of creditable coverage from a prior group health plan or insurer by requesting it within 24 months of coverage termination. We can help You obtain a certificate from a prior plan or insurer or suggest other documents that will serve as alternatives to a certificate of creditable coverage as provided by federal law.

URGENT CARE CENTER

We cover office visits for treatment of Illness or Injury. All other professional services not billed as an office visit, or that are not related to the actual visit (separate facility fees billed in conjunction with the office visit for example) are not considered an office visit under this provision. We also cover outpatient services and supplies (not billed as an office visit) provided by an Urgent Care Center. You may choose to see an In-Network or Out-of-Network Provider. See the Definitions Section of this Contract for a complete description of In-Network and Out-of-Network Providers. You can also go to **[web link]** for further Provider network information.

General Exclusions

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

PREEXISTING CONDITIONS

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

SPECIFIC EXCLUSIONS

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

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Cosmetic Services and Supplies

Cosmetic services and supplies.

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

Counseling in the Absence of Illness

We do not cover counseling in the absence of Illness. Examples of services not covered under this exclusion are as follows: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program ("EAP") services; wilderness programs; premarital or marital counseling; and family counseling when the identified patient is not a child or an adolescent with a covered diagnosis and family counseling is not part of the treatment.

Custodial Care

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

Dental Services

We do not cover Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth for Members age 19 and over.

Expenses Before Coverage Begins or After Coverage Ends

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

Fees, Taxes, Interest

Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Foot Care (Routine)
We do not cover routine foot care, including, but not limited to: treatment of corns and calluses and trimming of nails.

Government Programs
Except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid, We do not cover benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program. We do not cover government facilities outside the Service Area (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

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

Infertility Treatment

Investigational Services
Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section.

Mental Health Treatment For Certain Conditions
We will not cover Mental Health Conditions for diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) for all ages. Additionally, We will not cover any "V code" diagnoses except the following when Medically Necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger. By "V code," We mean codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the Diagnostic DSM-IV TR that describes Relational Problems, Problems Related To Abuse Or Neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.

Motor Vehicle No-Fault Coverage
Expenses for services and supplies that have been covered or have been accepted for coverage under any automobile medical personal injury protection ("PIP") no-fault coverage. If Your expenses for services and supplies have been covered or have been accepted for coverage by an automobile medical personal injury protection ("PIP") carrier, We will provide benefits according to the Contract once Your claims are no longer covered by that carrier.

Non-Direct Patient Care
Services that are not direct patient care, including:

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

Obesity or Weight Reduction/Control
We do not cover medical treatment, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction.

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

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.

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

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

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

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

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-medical self-care, training programs, including:

- diet and weight monitoring services;
- childbirth-related classes including infant care and breast feeding classes; and
- instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a Member of Your immediate family. For purposes of this provision, "immediate family" means parents, spouse, children, siblings, half-siblings, parent-in-law, child-in-law, sibling-in-law, half-sibling-in-law, or any relative by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary or Dentally Appropriate
We do not cover services and supplies that are not Dentally Appropriate for treatment or prevention of diseases or conditions of the teeth or Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
We do not cover non-mental health services and supplies for or in connection with sexual dysfunction regardless of cause.

Sexual Reassignment Treatment and Surgery
Treatment, surgery or counseling services for sexual reassignment.

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

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

Vision Care
We do not cover routine eye exam and vision hardware for Members age 19 and over.

Visual therapy, training and eye exercises, vision orthoptics, prism lenses, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. We may require the Member to file a claim for workers' compensation benefits before providing any benefits under the Contract. The only exception is if an Enrolled Employee is exempt from state or federal workers' compensation law. If the entity providing workers' compensation coverage denies Your claims and You have filed an Appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Third-Party Liability provision.

Contract and Claims Administration

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

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 resource use. 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.

ALTERNATIVE BENEFITS

To the extent mandated by Washington Administrative Code section 284-44-500, home health care furnished by duly licensed home health, hospice and home care agencies covered by this Contract may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home health care:

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

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

MEMBER CARD

When You, the Enrolled Employee, enroll with Regence BlueShield, You will receive a Member card. It will include important information such as Your identification number, Your Group number and Your name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling Our Customer Service department at 1 (888) 367-2112 or by visiting Our Web site at **[web link]**. If coverage under the Contract terminates, Your Member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

Our decision if We will pay the Member, Provider or Provider and Member jointly is made pursuant to any legal requirements. Payments are primarily issued as joint payee checks to both the Member and the Provider for Out-of-Network Provider claims. The exceptions would be if a Member submits sufficient documentation that they have "paid-in-full." In those circumstances, We may issue payment to the Member only.

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

Claims for the purchase of durable medical equipment will be submitted to this plan or any other Blue Cross and/or Blue Shield Licensee in the locale in which the equipment was received. Durable medical equipment is received where it is purchased at retail or, if shipped, where the durable medical equipment

is shipped to. Please refer to the plan network where supplies were received for coverage of shipped durable medical equipment.

Claims for independent clinical laboratory services will be submitted to this plan or any other Blue Cross and/or Blue Shield Licensee in the locale in which the specimen was drawn or otherwise acquired, regardless of where the examination of the specimen occurred. Please refer to the plan network where the specimen was drawn for coverage of independent clinical laboratory services**.**

Calendar Year and Contract Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. This Contract is renewed, with or without changes, each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. A Contract Year may or may not be the same as a Calendar Year. When Your Contract renews on other than January 1 of any year, the Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Contract renews will be carried over into the next Contract Year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Contract during that same Calendar Year.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. We will deny a claim that is not filed in a timely manner unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider

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

In-Network Provider Claims

You must present Your Member card when obtaining Covered Services from an In-Network Provider. You must also furnish any additional information requested. The Provider will furnish Us with the forms and information We need to process Your claim.

In-Network Provider Reimbursement

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

Out-of-Network Provider Claims

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

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

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

Out-of-Network Provider Reimbursement

In most cases, We will pay You directly for Covered Services provided by an Out-of-Network Provider.

Out-of-Network Providers may not agree to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

Ambulance Claims

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

Claims Determinations

Within 30 days of Our receipt of a claim, We will notify You of the action We have taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When We cannot take action on the claim due to circumstances beyond Our control, We will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when We expect to act on the claim.
- When We cannot take action on the claim due to lack of information, We will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

We must allow You at least 45 days to provide Us with the additional information if We are seeking it from You. If We do not receive the requested information to process the claim within the time We have allowed, We will deny the claim.

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain health care services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Us and other Blue Cross and Blue Shield Licensees.

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

BlueCard Program

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

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

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted

above. However, such adjustments will not affect the price We use for Your claim because they will not be applied retroactively to claims already paid.

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

Negotiated National Account Arrangements

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

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

Nonparticipating Providers Outside Our Service Area

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

BLUECARD WORLDWIDE®

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

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

- Always carry Your current Member card.
- If You need emergency medical care outside the United States, go to the nearest Hospital.
- If You are admitted, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.
- For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide Hospital or make an appointment with a Physician. BlueCard Worldwide Service Center staff are available to assist You 24 hours a day, 7 days a week.
- You will only be responsible for out-of-pocket expenses such as any applicable Deductible, Copayment, Coinsurance and non-Covered Services for Your inpatient care. For outpatient, Hospital care or Physician services, You will be responsible for paying the Hospital or Physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide Service Center for reimbursement of Covered Services.

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

NONASSIGNMENT

Only You are entitled to benefits under the Contract. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on Us. You may

not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

CLAIMS RECOVERY

If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right, at Our discretion, to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Enrolled Employee or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

We regularly work to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to Your Group's experience or the experience of the pool under which You or Your Group is rated. Crediting reduces claims expense and helps reduce future premium rate increases.

This claims recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the other-party liability provision in the Contract and Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by Us. This information will be used in accordance with Our Notice of Privacy Practices. You can request a copy simply by calling Our Customer Service department at 1 (888) 367-2112 or by visiting Our Web site at **[web link]**.

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

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

Health information requested or disclosed by Us may include, but is not limited to:

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

We are required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by calling Our Customer Service department or visiting Our Web site **[web link]**.

You have the right to request, inspect and amend any records that We have that contain Your personal health information. Please contact Our Customer Service department to make this request.

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

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Since We do not provide any health care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither Our employees nor agents. We are responsible for the quality of health care You receive only as provided by law.

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the Contract by reason of epidemic, disaster or other cause or condition beyond Our control.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

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

Third-Party Liability

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. We refer to the legally liable party as the "third party" in this provision. If You do not pursue a recovery of the benefits We have advanced, We may choose, in Our discretion, to pursue recovery from an automobile medical no-fault, personal injury protection ("PIP") carrier on Your behalf.

Here are some rules which apply in these third-party liability situations:

- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible third party, We will advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the third party in trust for Us to the extent it exceeds full compensation to You for the loss, up to the amount of benefits We paid in connection with the Illness or Injury.
- You and/or Your agent or attorney must agree to keep segregated in its own account the amount of the benefits We have paid for the condition from any recovery or payment of any kind for Your benefit or on Your behalf that is in any manner related to the Illness or Injury giving rise to Our right to reimbursement, until Our right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Injury or Illness through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which We have provided benefits, to the extent it exceeds full compensation to You for the loss. This is true regardless of whether:

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

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

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 motorists insurance. When We use the term motor vehicle insurance below, it includes medical expense coverage, personal injury protection coverage, uninsured motorists coverage, underinsured motorists 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 motorists coverage or underinsured motorists coverage for such expenses to the extent those payments exceed the amount necessary to fully compensate You, along with all other payments You receive to compensate You for Your Injuries, losses or damages, for those Injuries, losses or damages.

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

- If a claim for health care expenses arising out of a motor vehicle accident is filed with Us and motor vehicle insurance has not yet paid, We may advance benefits for Covered Services as long as You agree in writing:
  - to give Us information about any motor vehicle insurance coverage which may be available to You; and
  - to otherwise secure Our rights and Your rights.
- If We have paid benefits before motor vehicle insurance has paid, We are entitled to have the amount of the benefits We have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of You held in trust for Us. The amount of benefits We are entitled to will never exceed the amount You receive from all insurance sources that fully compensates You for Your loss and We will only seek to recover amounts You have received from other insurance sources to the extent those amounts exceed full compensation to You for Your Injuries, losses or damages.
- You may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the Third-Party Liability provision apply. However, We will not seek double reimbursement.

Workers' Compensation

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

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

- You must notify Us in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.
- If the entity providing workers' compensation coverage denies Your claims and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Third-Party Liability provision.

Fees and Expenses

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

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan. Plan is 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 another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Definitions

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

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

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

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

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

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

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the

same Allowable Expense that This Plan would have paid if it were the Primary Plan. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for You. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its Maximum Benefit plus any accrued savings.

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

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

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

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

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

Order of Benefit Determination Rules

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

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim cannot be less than the same Allowable Expense as the Secondary Plan would have paid if it was the Primary Plan. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need 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. We need not tell, or get the consent of, any person to do this. You, to claim benefits under This Plan, must give Us any facts We 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 another Plan, We have the right, at Our discretion, to remit to the other Plan the amount We determine appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, We are fully discharged from liability under This Plan.

Right of Recovery

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

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

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

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

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

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under the Contract and wish to have it reviewed, You may Appeal. There are two levels of Internal Appeal, as well as an External appeal with an Independent Review Organization You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

For Grievances or complaints not involving an Adverse Benefit Determination, please refer to the Grievance Process within this Contract.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueShield, P.O. Box 4208, MS E9A, Portland, OR 97208-4208 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (888) 367-2112.

Each level of Appeal, including Expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the first Internal level, within 180 days of Your receipt of Our original adverse decision that You are Appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement within 72 hours of receiving the request.

Upon request and free of charge, You, or Your Representative, have the right to review copies of all documents, records and information relevant to any claim that is the subject of the determination being appealed.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular Appeal process, You or Your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

If We reverse Our initial Adverse Benefit Determination, which We may do at any time during the review process, We will provide You with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

If You request a review of an Adverse Benefit Determination, We will continue to provide coverage for disputed inpatient care benefits or any benefit for which a continuous course of treatment is Medically Necessary, pending outcome of the review. If We prevail in the Appeal, You may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law.

Internal (First-Level) Appeals

First-level Internal Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are Appealing. You or Your Representative, on Your behalf, will be given a reasonable opportunity to provide written materials, including written testimony. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. If the Appeal involves a Post-Service investigational issue, a written notice of the decision will be sent within 20 working days after receiving the Appeal. For all other Appeals, the written notice will be sent within 14 days of receipt. You will be notified if, for good cause, We require additional time. An extension cannot delay the decision beyond 30 days without Your informed written consent.

Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel, the members of which were not involved in, or subordinate to anyone involved in, the previous decisions. You or Your Representative, on Your behalf, will be given a reasonable opportunity to provide written materials, including written testimony. If the Appeal involves a Post-Service investigational issue, a written notice of the decision will be sent within 20 working days after receiving the Appeal. For all other Appeals, the written notice will be sent within 14

days of receipt. You will be notified if, for good cause, We require additional time. An extension cannot delay the decision beyond 30 days without Your informed written consent.

We will provide You with any new or additional evidence or rationale considered in connection with Your Appeal. You will be given a reasonable opportunity to respond prior to the date of the final Internal Appeal decision. If You request an extension in order to respond, We will extend the final decision date for a reasonable amount of time, which will not be less than two days.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available to You if the Appeal involves an Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria and only after You have exhausted the internal level of Appeal, or We have failed to provide You with an Internal Appeal decision within the requirements of the Internal Appeal process.

We coordinate voluntary External Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Appeal documentation, which is available to You or Your Provider upon request. A written notice of the IRO's decision will be sent to You within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request. Choosing the voluntary External Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

The voluntary External Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with Us. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

EXPEDITED APPEALS

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

- You are currently receiving or are prescribed treatment for a medical condition; or
- Your treating Provider believes the application of regular Appeal timeframes on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

You may request concurrent expedited internal and external review of Adverse Benefit Determinations. When a concurrent expedited review is requested, We will not extend the timelines by making the determinations consecutively. The requisite timelines will be applied concurrently.

Internal Expedited Appeal

The internal Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. Internal Expedited Appeals are reviewed by a panel, the members of which were not involved in, or subordinate to anyone involved in, the initial denial determination. Reviewers will include an appropriate clinical peer in the same or similar specialty as would typically manage the case. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals timeframe) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within 72 hours of the date of decision.

Voluntary Expedited Appeal - IRO

If You disagree with the decision made in the internal Expedited Appeal and You or Your Representative reasonably believes that preauthorization or concurrent care (Pre-Service) remains clinically urgent, You may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Appeal at the same time You request an Expedited Appeal from Us.

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Expedited Appeal documentation, which is available to You or Your Provider upon request. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of the IRO's receipt of the necessary information. This will be followed by written notification within three working days of the verbal notice. Choosing the voluntary Expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

The voluntary Expedited 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 with Us, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If You have any questions about the Appeal process outlined here, You may contact Our Customer Service department at 1 (888) 367-2112 or You can write to Our Customer Service department at the following address: Regence BlueShield, P.O. Box 30271, Salt Lake City, UT 84130-0271.

ASSISTANCE

For assistance with internal claims and Appeals and the external review process, You may contact:

Office of the Insurance Commissioner
Consumer Protection Division
PO Box 40256
Olympia, WA 98504-0256
Toll Free: 1 (800) 562-6900
TDD: 1 (360) 586-0241
Olympia: 1 (360) 725-7080
Fax: 1 (360) 586-2018
E-mail: **cap@oic.wa.gov**
Web: **www.insurance.wa.gov**

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 a denial, reduction, termination or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

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

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

Expedited Appeal means an Appeal where:

- You are currently receiving or are prescribed treatment for a medical condition; and
- Your treating Provider believes the application of regular Appeal timeframes on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or

- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

External Appeal means a review of an Adverse Benefit Determination performed by an Independent Review Organization to determine whether Regence's Internal Appeal decisions are correct.

Grievance means a written or oral complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

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

Internal Appeal means a review and reconsideration of an Adverse Benefit Determination performed by Regence.

Investigational means a Health Intervention that We have classified as Investigational. For a full definition of Investigational, please refer to Investigational in the Definitions section of this Contract.

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

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

Grievance Process

If You or Your Representative (any Representative authorized by You) has a complaint not involving an Adverse Benefit Determination and wishes to have it resolved, You may submit a Grievance to Us. Grievances may be submitted orally or in writing through either of the following contacts:

Call Our Customer Service department: 1 (888) 367-2112 or You can write to Our Customer Service department at the following address: Regence BlueShield, P.O. Box 30271, Salt Lake City, UT 84130-0271.

A Grievance may be registered when You or Your Representative expresses dissatisfaction with any matter not involving an Adverse Benefit Determination, including but not limited to our customer service or quality or availability of a health service. Once received, Your Grievance will be responded to in a timely and thorough manner. Grievances will also be collectively evaluated by Us, on a quarterly basis, for improvements. If You would like a written response or acknowledgement of Your Grievance from Us, please request at the time of submission.

For any complaints involving an Adverse Benefit Determination, please refer to the Appeals Process section within this Policy.

DEFINITONS SPECIFIC TO THE GRIEVANCE 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 a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or 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.

Grievance means a written or oral complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

Who Is Eligible, How to Enroll and When Coverage Begins

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Group and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective 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 Group long enough to satisfy any required probationary period.

Dependents

Your Enrolled Dependents are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when We have enrolled them in coverage under the Contract. Dependents are limited to the following:

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

Our affidavit of dependent eligibility form is available by visiting Our Web site at **[web link]**, or by calling Our Customer Service department at 1 (888) 367-2112. We may request updates on the child's disability or handicap at reasonable times as We consider 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 (and, for a non-registered domestic partner, an affidavit of

qualifying domestic partnership form) to Us. Application for enrollment of a new child by birth, adoption or Placement for Adoption must be made within 60 days of the date of birth, adoption or Placement for Adoption if payment of additional premium is required to provide coverage for the child. Application for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates. For a new child by birth, the Effective Date is the date of birth. For a new child adopted or placed for adoption within 60 days of birth, the Effective Date is the date of birth, if any associated additional premium has been paid within 60 days of birth. The Effective Date for any other child by adoption or Placement for Adoption is the date of Placement for Adoption. For other newly eligible dependents, the Effective Date is the first day of the month following receipt of the application for enrollment.

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

SPECIAL ENROLLMENT

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

Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children (or, if you are a child, You and Your parent who is not enrolled on this same plan) are eligible to apply for coverage under the Contract within 60 days from the date of the qualifying event:

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

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

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

If You are already enrolled or if You declined coverage when first eligible and You subsequently marry or begin a domestic partnership, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 30 days from the date of

the qualifying event. If enrollment is requested as specified, coverage will be effective as of the first of the calendar month following the marriage or commencement of the domestic partnership.

If You are already enrolled or if You declined coverage when first eligible and have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 60 days from the date of the qualifying event:

- You and/or Your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).
- The Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective for an eligible dependent to have coverage under the Contract.

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

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 30 days from the date of the qualifying event:

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

If You are already enrolled or if You declined coverage when first eligible and subsequently You and/or Your eligible dependent exhausts any lifetime maximum on total benefits under another group or individual health benefit plan, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 30 days from the date the first claim is denied under that other health benefit plan on the basis of lifetime maximum exhaustion.

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

You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 30 days from losing group coverage as a result of any of the following qualifying events:

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

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

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the period of time before the Group's Renewal Date and is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form (and, in the case of a non-registered domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

When Group Coverage Ends

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. You must notify Us within 30 days of the date on which an Enrolled Dependent is no longer eligible for coverage.

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

CONTRACT TERMINATION

If the Contract is terminated or not renewed by the Group or Us, coverage ends for You and Your Enrolled Dependents on the date the Contract is terminated or not renewed.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents' coverage ends on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, Your coverage will end for You and all Enrolled Dependents on the last day of the monthly period in which eligibility ends.

NONPAYMENT OF PREMIUM

If You fail to make required timely contributions to premium, Your coverage will end for You and all Enrolled Dependents.

FAMILY AND MEDICAL LEAVE

If Your Group 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. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. 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:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - in order to care for Your newly born child;
    - in order to care for Your spouse, domestic partner, child or parent, if such spouse, domestic partner, child or parent has a serious health condition;
    - the placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or Mental Health Condition.

During the FMLA leave, You must continue to pay the monthly premium through the Group on time. The provisions described here will not be available if the Contract terminates.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the FMLA leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form just as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period

under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Group must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your Group, You can continue coverage for up to three months. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of the Group. A leave can be granted for any reason acceptable to the Group. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Contract only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Enrolled Dependents) may reenroll under the Contract only during the next annual enrollment period.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

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

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 monthly period following the date a divorce or annulment is final.

If You Die

If You die, coverage for Your Enrolled Dependents ends on the last day of the monthly period in which Your death occurs.

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership for a non-registered domestic partner within 90 days after a request for termination of a domestic partnership has been received. This termination provision does not apply to any termination of domestic partnership that occurs as a matter of law because the parties to the

domestic partnership enter into a marriage (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage).

Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.
- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION

Members may be terminated for any of the following reasons. However, it may be possible for them to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

We have issued the Contract in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding a Member (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Group), We will take any action allowed by law or Contract, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Contract should be directed to the Group, or to Us at P.O. Box 30271, Salt Lake City, UT 84130-0271.

COBRA Continuation of Coverage

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

If Your Group is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

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

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

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

General Rules

Generally, You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

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

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

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

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize Your or Your Enrolled Dependents' future eligibility for an individual plan.

Notice

The Contract includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your Group.

After You and/or Your Enrolled Dependents' term of COBRA continuation coverage has been exhausted, a policy of conversion may be available.

Non-COBRA Continuation of Coverage

You and Your Enrolled Dependents are entitled to continuation of Group coverage benefits upon loss of eligibility for coverage.

The Group must notify You and Your Enrolled Dependents of this continuation right. If You and/or Your Enrolled Dependents do not receive notice, You may contact Us directly within 60 days following termination of coverage and elect continuation of coverage.

If You and/or Your Enrolled Dependents choose to continue coverage under this right, You must enroll in writing and pay the premium for such coverage within 60 days of coverage termination. You will be required to make timely premium payments to the Group. The Group may charge You and Your Enrolled Dependents a premium no higher than the current rate paid for coverage of a comparable Member (or Members) who lost coverage and the Group is not required to make any contribution toward premiums for continuation coverage. Where an enrollment form and premium are received within the 60-day period, the accepting Member's coverage continues, without interruption, from the date the Member's coverage was terminated.

This continuation of coverage will terminate when the first of the following occurs:

- You and/or Your Enrolled Dependents fail to make payment of premiums for the coverage to the Group within its established timeframe;
- one month elapses; or
- the Group's coverage is terminated.

If the Group replaces coverage with a similar plan, those who have continued coverage may obtain coverage under the replacement policy for the balance of the period that they would have been allowed to extend benefits under the replaced coverage.

If Your Group is required to offer COBRA continuation of coverage, You may continue group coverage under both COBRA and this non-COBRA continuation of coverage. In almost all cases, COBRA offers greater benefits with fewer restrictions than this continuation of coverage. However, administration will be according to whichever law offers the greatest benefit to You. The maximum number of months You may continue coverage will never be more than the number available under COBRA.

After You and/or Your Enrolled Dependents' term of continuation coverage has been exhausted, a policy of conversion may be available.

Conversion

When eligibility under the Contract terminates, and You are under age 65 and ineligible for Medicare, You will be allowed to enroll under one of Our conversion plans. To be eligible, We must receive Your application within 31 days following termination of coverage under this Contract. You will not be required to complete a health statement. The benefits of the conversion plan will be the standard individual medical and Hospital benefits coverage in effect at the date of conversion that We customarily offer to Members upon termination of coverage. It is very likely that rates under the conversion plan will be higher than for this Contract and benefits will be substantially less. Coverage under the conversion plan will be subject to the same waiting period provisions as this Contract. However, any dependents added to the conversion plan after the Enrolled Employee's Effective Date will be subject to the waiting periods of the conversion plan. By enrolling in a conversion plan, You may lose the right to enroll without submitting a health questionnaire under one of Our marketed individual plans (see the Other Continuation Options Section for additional information on individual plans).

If the Contract with the entire Group terminates and the Group transfers its health care plan to another Contract with Us, to another carrier or to a self-funded plan and You are covered under that plan, this conversion option does not apply.

Other Continuation Options

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

Medicare Supplement Or Individual Contract

When eligibility under the Contract terminates, You may be eligible for coverage under an individual insurance policy or a Medicare supplement plan through Us. Additional information is available by calling Customer Service at 1 (888) 367-2112.

If You choose to enroll in a conversion plan (discussed earlier), You may lose the right to enroll in one of these plans without submitting a health questionnaire.

- If You are eligible for Medicare, You may be eligible for coverage under one of Our Medicare supplement plans. To be eligible for continuous coverage, We must receive Your application within 31 days following Your termination from the Contract. If You apply for a Medicare supplement plan within six months of enrolling in Medicare Part B coverage, We will not require a health statement. After the six-month enrollment period, We may require a health statement. Benefits and premiums under the Medicare supplement plan will be substantially different from the Contract.
- If You are not eligible for Medicare, You may be eligible for coverage under one of Our individual plans. To be eligible, You must submit a completed application form and health questionnaire, if applicable, and must be accepted by Us for coverage. Benefits and premiums under the individual plan may be substantially different from the Contract.

If the Contract with the entire Group terminates and the Group transfers its health care plan to another Contract with Us, to another carrier or to a self-funded plan and You are covered under that plan, this continuation option does not apply.

Strike, Lockout Or Other Labor Dispute

If the Enrolled Employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, the Enrolled Employee may continue coverage under the Contract for himself or herself and Enrolled Dependents during the dispute for a period not exceeding six months, by paying the necessary premiums for Your coverage through the Group. This provision will not apply if the Enrolled Employee and Enrolled Dependents are eligible for COBRA.

If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full premium, including any part usually paid by the Group, directly to the union or trust that represents You. And the union or trust must continue to pay Us the premiums according to the Contract. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Contract.

General Provisions

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

CHOICE OF FORUM

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

ERISA (IF APPLICABLE)

This provision applies if the Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

The Group intends that the Contract be maintained for the exclusive benefit of the employees.

The Group intends to continue this coverage indefinitely, but it also reserves the right to discontinue or change this coverage at any time. If the Group terminates the Contract for any reason and does not replace the coverage with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

Rights and Protection

Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.
- If the plan has an exclusion period for a Preexisting Condition, reduce or eliminate periods that coverage for Preexisting Conditions is excluded, when they have creditable coverage from another plan. Group plans and health insurance issuers should provide a certificate of creditable coverage, free of charge, when an employee loses that other coverage, when he or she becomes entitled to elect COBRA continuation under it, when COBRA continuation is exhausted and if an employee requests one within 24 months after losing that other coverage. Without evidence of creditable coverage, an employee may not have coverage for Preexisting Conditions, if any, as further specified in the General Exclusions Section.

Duties

In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to Appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the plan administrator in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

Denied Claims

If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting his or her rights, employees may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, he or she should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

GOVERNING LAW AND BENEFIT ADMINISTRATION

The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the State of Washington without regard to its conflict of law rules. We are not the plan administrator, but are a health care service contractor that provides health care coverage to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Member rights under this benefit plan that include the right to appeal, review by an Independent Review Organization and civil action.

GROUP IS AGENT

The Group is Your agent for all purposes under the Contract and not the agent of Regence BlueShield. You are entitled to health care benefits pursuant to an agreement between Us and the Group. In the Contract, the Group agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Contract. You, through the enrollment form signed by the Enrolled Employee, and as beneficiaries of the Contract, acknowledge and agree to the terms, provisions, limitations and exclusions of the Contract.

MODIFICATION OF CONTRACT

We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to Members or to the Group, and modification must be uniform within the product line and at the time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract. No modification or amendment of the Contract will affect the benefits of any Member who is, on the Effective Date of such modification or amendment, confined in a Hospital or other facility on an inpatient basis, until the first discharge from such facility occurring after such Effective Date.

NO WAIVER

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

NOTICES

Any notice to Members or to the Group required in the Contract will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form

(COA) for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to: Regence BlueShield, P.O. Box 30271, Salt Lake City, UT 84130-0271; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

PREMIUMS

Premiums are to be paid to Us by the Group, in advance, and on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's or Member's coverage on the last day of the monthly period through which premiums are paid or such later date as is provided by applicable law.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Members expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group 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 Us to use the Blue Shield Service Mark in the state of Washington, for those counties designated in Our Service Area, and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract 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 Group or the Members for any of Our obligations to the Group or the Members created under the Contract. 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 Contract.

REPRESENTATIONS ARE NOT WARRANTIES

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

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under the Contract, 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 of the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person for the current month has been paid by the Group on a timely basis.

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

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

Allowed Amount means:

- For In-Network Providers (see definition of "In-Network Provider" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network Provider" below), the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

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

Affiliate means a company with which We have a relationship that allows access to providers in the state in which the Affiliate serves and includes 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.

Ambulatory Service Facility means a facility, licensed by the state in which it is located, that is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us.

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

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

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

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

Effective Date means the date specified by Us, following Our receipt of the enrollment form, as the date coverage begins for You and/or Your dependents.

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

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

Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

Enrolled Employee means an employee of the Group who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage.

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

Family means an Enrolled Employee and his or her Enrolled Dependents.

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

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

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

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

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

In-Network Provider means a Provider that has an effective participating contract and an effective preferred addendum or agreement with Us or one of our Affiliates which designates him, her or it as a preferred Provider to provide services and supplies to Members in accordance with the provisions of this coverage.

In-Network Provider also means Providers outside the area that We or one of Our Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Preferred Provider Organization ("PPO")") to provide services and supplies to Members in accordance with the provisions of this coverage. For In-Network Provider reimbursement, You will not be charged for balances beyond the Deductible, Copayment and/or Coinsurance for Covered Services.

Investigational means a Health Intervention that We have classified as Investigational. We will review Scientific Evidence from well-designed clinical studies found in Peer-Reviewed Medical Literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria, is, in Our judgment, 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, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Upon receipt of a fully documented claim or request for preauthorization related to a possible Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Please contact Us by calling Our Customer Service department at 1 (888) 367-2112 or by visiting Our Web site at **[web link]** for details on the information needed to satisfy the fully documented claim or request requirement. You may also have the right to an Expedited Appeal. Refer to the Appeal Process Section for additional information on the Appeal process.

Lifetime means the entire length of time a Member is covered under the Contract (which may include more than one coverage) through the Group with Us.

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

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

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

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

Member means an Enrolled Employee or an Enrolled Dependent.

Out-of-Network Provider refers to Providers that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to the Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that We or one of Our Affiliates serves.

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

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

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and other professionals practicing within the scope of his or her respective licenses.

Primary Provider means a Physician or Practitioner who is a general or family practitioner; an internist; a pediatrician or an obstetrical/gynecologist (Ob/Gyn) who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed.

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

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

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

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

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 or Practitioner that does not otherwise meet the definition of a Primary Provider or Practitioner.