Asuris Northwest Health Policy

Individual Group Number: 38000001

2023 Medical Benefits

WA0123PEPOD

Your Rights and Protections Against Surprise Medical Bills and Balance Billing In Washington State

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

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

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals and air ambulance providers, can **never** require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are **never** required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (preauthorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at their website or by calling 1-800-562-6900.

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

Visit the Office of the Insurance Commissioner Balance Billing Protection Act website for more information about your rights under Washington state law.

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

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

Customer Service for all other plans
1-888-232-8229 (TTY: 711)

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

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

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-232-8229 (TTY: 711)
CS@Asuris.com

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-232-8229 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-232-8229 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-232-8229 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-232-8229 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-232-8229 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-232-8229 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-232-8229 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-232-8229（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-232-8229 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-232-8229 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-232-8229 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-232-8229 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-232-8229 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-232-8229 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-232-8229 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-232-8229 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-232-8229 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-232-8229 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-232-8229 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-232-8229 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-232-8229 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-232-8229 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-232-8229 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-232-8229 (رقم هاتف الصم والبكم TTY: 711)

SCHEDULE OF BENEFITS

Gold 2000

This Schedule of Benefits provides information regarding Your cost-shares for Covered Services and how Provider choice affects Your out-of-pocket expenses. This Schedule of Benefits is part of Your Policy. Read the entire Policy to understand the benefits, limitations, exclusions, defined terms, and provisions of Your coverage.

	Insured Responsibility
	In-Network Provider Only
Coinsurance	10%
Deductible per Calendar Year • Except as noted with "Deductible waived," all benefits are subject to the Deductible and the Deductible must be met before benefits begin for any Insured. However, no one Insured will be required to meet more than the individual Deductible amount toward the Family Deductible.	$2,000 per Insured $4,000 per Family
Out-of-Pocket Maximum per Calendar Year	$9,100 per Insured $18,200 per Family

YOUR PROVIDERS AND OUT-OF-POCKET EXPENSES

To receive benefits for Covered Services, this plan requires You see Providers in Your network (In-Network Providers) and to live in the Service Area. Services received from Providers outside of Your network (Out-of-Network Providers) will not be covered except for Ambulance, Blood Bank, Emergency Room, and Urgent Care services. A list of In-Network Providers is available on Our Web site or You may also call Us to verify that Your Provider is an In-Network Provider.

This plan uses the following networks:

Individual and Family Network medical network
VSP Choice vision network
Participating Dental network

The Service Area for this plan is Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman Counties in the state of Washington.

A Primary Care Provider (PCP) is a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who has a specialty type of general practice, family practice, internal medicine, pediatrics, geriatrics, OB/GYN and obstetrics, preventive medicine, adult medicine, or is a women's health care practitioner or naturopath. A PCP also includes any physician assistant, nurse practitioner or advance registered nurse practitioner if their primary specialty is one of the above and they are working under the license of an M.D. or D.O. in these specialties.

A Specialist is a Physician, Practitioner or urgent care center that does not otherwise meet the definition of a PCP.

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility** **In-Network Provider Only**
Preventive Care and Immunizations	0%, Deductible waived
Preventive Care – Expanded Immunizations	10%
Office or Urgent Care Center Visits – Illness or Injury • Outpatient services and supplies (not billed as an office visit) provided by an urgent care center are covered. • Out-of-Network urgent care center visits are covered and apply to the In-Network Out-of-Pocket Maximum.	PCP – $20 Copayment, Deductible waived Specialist (including urgent care) – $70 Copayment, Deductible waived
Other Professional Services	10%
Acupuncture • 12 visits per Calendar Year	$20 Copayment, Deductible waived
Ambulance Services • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	10%
Blood Bank • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	10%
Dental Hospitalization	10%
Detoxification	10%
Diabetic Education	0%, Deductible waived
Dialysis	10%
Durable Medical Equipment	10%
Emergency Room • Out-of-Network services are covered and apply to the In-Network Deductible and In-Network Out-of-Pocket Maximum.	10%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility** **In-Network Provider Only**
Gene Therapy and Adoptive Cellular Therapy	Centers of Excellence facility – 10%
Gene Therapy and Adoptive Cellular Therapy – Travel Expenses • $7,500 per course of treatment, including companion(s), for transportation and lodging expenses • Additional limitations apply, refer to the Medical Benefits Section	100% of all expenses. Your travel expenses may be reimbursed subject to Your In-Network Deductible and travel expense limit.
Habilitation Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	10%
Home Health Care • 130 visits per Calendar Year	10%
Hospice Care • 14 days for respite care per Lifetime	10%
Hospital Care – Inpatient, Outpatient and Ambulatory Surgical Center	10%
Infusion Therapy	10%
Maternity Care	10%
Medical Foods	10%
Mental Health Services	Inpatient services – 10% Outpatient office/psychotherapy visits – $20 Copayment, Deductible waived All other outpatient services – 10%
Neurodevelopmental Therapy • 25 professional visits per Calendar Year	10%
Newborn Care	10%
Nutritional Counseling	10%
Orthotic Devices	10%
Palliative Care • 30 visits per Calendar Year	10%
Prosthetic Devices	10%

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility** **In-Network Provider Only**
Reconstructive Services and Supplies	10%
Rehabilitation Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	10%
Reproductive Health Care Services	0%, Deductible waived
Skilled Nursing Facility • 60 inpatient days per Calendar Year	10%
Spinal Manipulations • 10 spinal manipulations per Calendar Year	$20 Copayment, Deductible waived
Substance Use Disorder Services	Inpatient services – 10% Outpatient office/psychotherapy visits – $20 Copayment, Deductible waived All other outpatient services – 10%
Temporomandibular Joint (TMJ) Disorders	10%
Transplants	10%
Virtual Care – Store and Forward Services	0%, Deductible waived
Virtual Care – Telehealth	$10 Copayment, Deductible waived
Virtual Care – Telemedicine	10%

<table>
<tr><th colspan="2">Covered Services (per Insured)
Unless Otherwise Noted the Deductible Applies</th></tr>
<tr><th rowspan="2">Benefit</th><th>Insured Responsibility</th></tr>
<tr><th>Participating Pharmacy Only</th></tr>
<tr><td rowspan="5">No coverage for Prescription Medications not on the Drug List or Prescription Medications from a Nonparticipating Pharmacy.

Your cost-sharing will be applied to the In-Network Deductible (if Deductible applies) and In-Network Out-of-Pocket Maximum.

Prescription Medications – from a Pharmacy

• Deductible waived for medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. To obtain this list visit Our Web site or contact Customer Service. Contact Information is available in the Introduction Section.
• You are not responsible for any Deductible, Copayment and/or Coinsurance when You fill prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List. To obtain this list visit Our Web site or contact Customer Service. Contact Information is available in the Introduction Section.
• Deductible waived when You fill prescriptions for insulin and covered diabetic supplies.
• 90-day supply for Prescription Medications.
• 30-day supply for Specialty Medications.
• 90-day supply for Self-Administrable Injectable Medications.
• Copayment is based on each 30-day supply.
• Cost-sharing for insulin will not exceed $35 per 30-day supply, and Your cost-share will be applied to the Deductible.
• Up to a 12-month supply for refills of FDA-approved contraceptive drugs (may be dispensed on-site at a Provider’s office, if available).</td><td>$5 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List</td></tr>
<tr><td>20%, Deductible waived for each Generic Medication on the Drug List</td></tr>
<tr><td>30% for each Preferred Brand-Name Medication on the Drug List</td></tr>
<tr><td>50% for each Brand-Name Medication on the Drug List</td></tr>
<tr><td>40% for each Preferred Specialty Medication on the Drug List from a Participating Specialty Pharmacy</td></tr>
<tr><td>50% for each Specialty Medication on the Drug List from a Participating Specialty Pharmacy</td></tr>
</table>

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility** **Participating Pharmacy Only**
Prescription Medications – from a Home Delivery (Mail-Order) Supplier • 90-day supply for Self-Administrable Injectable Medications. • 90-day supply for Prescription Medications. • Cost-sharing for insulin will not exceed $105 per 90-day supply, and Your cost-share will be applied to the Deductible. • Up to a 12-month supply for refills of FDA-approved contraceptive drugs (may be dispensed on-site at a Provider's office, if available).	$15 Copayment, Deductible waived for each Preferred Generic Medication on the Drug List
	20% Deductible waived for each Generic Medication on the Drug List
	30% for each Preferred Brand-Name Medication on the Drug List
	50% for each Brand-Name Medication on the Drug List
Self-Administrable Cancer Chemotherapy Medications • 30-day supply	10%, Deductible waived for each Preferred Generic and Generic Medication on the Drug List
	10% for each Preferred Brand-Name and Brand-Name Medication on the Drug List.
	10% for each Preferred Specialty and Specialty Medication on the Drug List. Preferred Specialty or Specialty Medication must be provided by a Specialty Pharmacy.

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility** **VSP Doctor Only**
Pediatric Vision (under age 19) • 1 routine eye examination per Calendar Year. • 1 frame per Calendar Year. • 1 pair of lenses (2 lenses) per Calendar Year. • Contacts may be selected (once per Calendar Year) instead of frames and lenses. • Low vision supplemental testing and supplemental aids every 2 Calendar Years. • Additional limitations apply, refer to the Medical Benefits Section.	Examination – $0 Copayment, Deductible waived
	Hardware – $0 Copayment, Deductible waived
	Contact Lens Evaluation and Fitting Examination – $0 Copayment, Deductible waived
	Low Vision Supplemental Testing – $0 Copayment, Deductible waived
	Low Vision Supplemental Aids – $0 Copayment, Deductible waived

Covered Services (per Insured) Unless Otherwise Noted the Deductible Applies	
Benefit	**Insured Responsibility** **In-Network Dentist Only**
Pediatric Dental (under age 19) • Additional limitations apply, refer to the Medical Benefits Section.	Preventive and Diagnostic Services – 0%, Deductible waived
	Basic Services – 20%, Deductible waived
	Major Services – 50%, Deductible waived

Introduction

Asuris Northwest Health

Street Address:
528 E. Spokane Falls Blvd., Suite 301
Spokane, WA 99202

Medical/Pediatric Dental Claims Address:
P.O. Box 1106
Lewiston, ID 83501-1106

Pediatric Vision Claims Address:
Vision Service Plan
P.O. Box 385020
Birmingham, AL 35238-5020

Medical/Pediatric Dental Customer Service/Correspondence Address:
P.O. Box 1827, MS CS B32B
Medford, OR 97501-9884

Pediatric Vision Customer Service/Correspondence Address:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Medical/Pediatric Dental Appeals Address:
Attn: Member Appeals
P.O. Box 1408
Lewiston, ID 83501

Pediatric Vision Appeals Address:
Attn: Complaint and Grievance Unit
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

In this Policy, the terms "We," "Us" and "Our" refer to Asuris Northwest Health and the term "Policyholder" means a person who is enrolled for coverage with Asuris Northwest Health and whose name appears on the records as the individual to whom this Policy was issued. References to "You" and "Your" refer to the Policyholder and/or Enrolled Dependents. Policyholder does not mean a dependent of this Policy. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

POLICY

This Policy describes benefits effective **December 1, 2023**, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage.

Asuris Northwest Health agrees to provide benefits for Medically Necessary services as described in this Policy, subject to all of the terms, conditions, exclusions and limitations in this Policy, including endorsements affixed hereto. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by the Policyholder for and on behalf of the Policyholder and/or any Enrolled Dependents listed in this Policy, which are hereby referred to and made a part of this Policy.

RENEWABILITY

This Policy is guaranteed renewable at the option of the Policyholder subject to receipt of the monthly premium when due or within the grace period.

EXAMINATION OF POLICY

If, after examination of this Policy, the Policyholder is not satisfied for any reason with this Policy, the above-named Policyholder will be entitled to return this Policy within ten days after its delivery date. If the

Policyholder returns this Policy to Us within the stipulated ten-day period, such Policy will be considered void as of the original Effective Date and the Policyholder generally will receive a refund of premiums paid, if any. If benefits already paid by this Policy exceed the premiums paid by the Policyholder, We will be entitled to retain the premiums paid and the Policyholder will be required to repay Us for the amount of benefits paid in excess of premiums. We shall pay the Policyholder an additional ten percent of the refund amount if such refund is not made within 30 days of the return of this Policy to Us.

ESSENTIAL HEALTH BENEFITS

This coverage complies with the essential health benefits in the following ten categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services (including behavioral health treatment);
- prescription drugs;
- rehabilitation and habilitation services and devices;
- laboratory services;
- preventive and wellness services;
- chronic disease management; and
- pediatric services including oral and vision care.

There is no annual or Lifetime maximum applicable to these services.

OPEN ENROLLMENT PERIOD

The open enrollment period is the period of time, as designated by law, during which You and/or Your eligible dependents may enroll.

NOTICE OF PRIVACY PRACTICES

Asuris Northwest Health 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) 232-8229
(TTY: 711)

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m., Pacific Time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- to request a copy of Your identification card or print a copy via Our Web site if You have not received or have lost Your identification card;
- if You would like to request written or electronic information regarding any other plan that We offer;
- to talk with one of Our Customer Service representatives;
- via Our Web site, **asuris.com**, to submit a claim online or chat live with a Customer Service representative; or
- for assistance in a language other than English.

Pediatric Vision Services – Vision Service Plan (VSP): 1 (844) 299-3041
(hearing impaired: 1 (800) 428-4833)

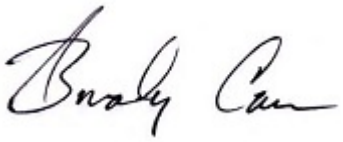
VSP phone lines are open Monday – Friday 5 a.m. – 8 p.m., Saturday 7 a.m. – 8 p.m. and Sunday 7 a.m. – 7 p.m.

Contact VSP if You have Provider or benefit questions specific to Your pediatric vision coverage. You may also visit VSP's Web site at **www.vsp.com**.

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

Health Plan Disclosure Information. You may receive written or electronic copies of the following health plan disclosure information by calling the Customer Service telephone number or access that information through Our Web site at https://www.asuris.com/web/asuris_individual/all-forms. Available disclosure information includes, but is not limited to:

- a listing of covered benefits, including prescription drug benefits;
- a copy of the current Drug List;
- a list of contracted health care benefit managers acting on Our behalf in the utilization of health care services;
- exclusions, reductions, and limitations to covered benefits;
- our Policies for protecting the confidentiality of Your health information;
- cost of premiums and Insured cost-sharing requirements;
- a summary of Adverse Benefit Determinations and the Grievance Processes; and
- lists of In-Network primary care and specialty care Providers.



Brady D. Cass
President
Asuris Northwest Health

Using Your Policy

ACCESSING PROVIDERS

For each benefit, We indicate in the Schedule of Benefits the Provider You may choose and Your payment amount for each provider option. See the Schedule of Benefits and the Definitions Section for a complete description of In-Network and Out-of-Network. You can go to **asuris.com** for further Provider network information.

If the Schedule of Benefits indicates that Your plan requires selection of a Primary Care Provider (PCP), the following conditions apply:

- You may change the Provider of Your care (including primary care) at any time by consulting a different Provider.
- If We terminate the contract of Your PCP without cause, We will continue to cover Your PCP, on the same terms, for at least 90 days following notice of termination.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to Our Web site to help You navigate Your way through health care decisions. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR POLICY.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of this Policy.

- **Go to asuris.com.** You can use Our secure Web site to:
    - view recent claims, benefits and coverage;
    - find a contracting Provider or identify Participating Pharmacies;
    - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
    - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
    - learn about prescriptions for various Illnesses;
    - compare medications based upon performance and cost and get assistance in switching to less costly, equally effective alternative medications, if You wish; and
    - access information about Asuris Advantages. Asuris Advantages is a discount program that gives You access to savings on a variety of health-related products and services. We have contracted with several program partners, listed on the secure Web site, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by Your Policy, that also may create savings or administrative fees for Us. Any such discounts or coupons are complements to the individual Policy, but are not insurance. Services may be provided through third-party program partners who are solely responsible for their services. These program partners are not considered Providers under Your health plan.

Table of Contents

Understanding Your Benefits

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

MAXIMUM BENEFITS

Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Refer to the Schedule of Benefits to determine if a Covered Service has a specific Maximum Benefit.

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

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before We will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is an individual Deductible amount and a Family Deductible amount.

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

We do not pay for services applied toward the Deductible. Refer to the Schedule of Benefits to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible. For additional information on how Prescription Medications apply to Your Deductible, refer to the Prescription Medications Section.

COPAYMENTS

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

COINSURANCE (PERCENTAGE YOU PAY)

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

An In-Network Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible, Copayment and/or Coinsurance amount. We generally do not cover services provided by Out-of-Network Providers; when Out-of-Network Providers are eligible to provide Covered Services, however, Out-of-Network Providers may bill You for any balances over Our payment level in addition to the Deductible, Copayment and/or Coinsurance amount.

BALANCE BILLING

Balance billing occurs when You are billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services provided to You by an Out-of-Network Provider when the Out-of-

Network Provider's billed amount is not fully reimbursed by Us. You will not be balance billed for emergency services or for certain non-emergency surgical or ancillary services provided by an Out-of-Network Provider at an In-Network hospital or Ambulatory Surgical Center. Non-emergency surgical or ancillary services include anesthesiology, pathology, radiology, laboratory, hospitalist, or surgical services. Any amounts You pay for emergency services or for non-emergency surgical or ancillary services will count toward Your Deductible and Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. There is an individual Out-of-Pocket Maximum amount and a Family Out-of-Pocket Maximum amount.

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

Any amounts You pay for non-Covered Services and amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. For additional information on how Prescription Medications apply to Your Out-of-Pocket Maximum, refer to the Prescription Medications Section. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach any applicable Out-of-Pocket Maximum.

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

HOW CALENDAR YEAR BENEFITS RENEW

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

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

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

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

Medical Benefits

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

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

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

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

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

CASE MANAGEMENT

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

PREAUTHORIZATION

We will not require preauthorization for emergency medical services, including admissions for emergency detoxification, or involuntarily committed mental health services provided by a state Hospital. No preauthorization is required for childbirth admissions, or admissions for newborns that need medical care at birth.

Some Covered Services may require preauthorization. Those services require contracted Providers to obtain preauthorization from Us before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from Us in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from Us prior to providing Covered Services. You may be responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) are covered for the following:

- routine physical examinations, well-baby care, women's care (including screening for gestational diabetes), and health screenings. Health screenings include screening for obesity in patients ages six and older, and appropriate referrals to comprehensive, intensive behavioral interventions to promote improvements in weight status;
- intensive multicomponent behavioral interventions for weight management;
- Provider counseling and prescribed medications for tobacco use cessation;
- preventive mammography services, including tomosynthesis;
- depression screening for all adults, including screening for maternal depression;
- immunizations for adults and children as recommended by the USPSTF, HRSA and CDC;
- breastfeeding support and one new non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from an In-Network Provider (including a Durable Medical Equipment supplier), or a comparable new breast pump obtained from an approved Commercial Seller, even though that seller is not a Provider; and
- Food and Drug Administration (FDA) approved contraceptive drugs, devices, products and services (including vasectomy) as described under the Reproductive Health Care Services benefit.

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

For a complete list of services covered under this benefit, including information about how to access an approved Commercial Seller, obtaining a new breast pump and instructions for obtaining reimbursement for a new breast pump purchased from an approved Commercial Seller, retailer, or other entity that is not a Provider, visit Our Web site or contact Customer Service. If You choose to access new medical supplies, equipment, and devices through Our Web site, We may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to Your Policy, but are not insurance.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, We have up to one year before coverage of the related services must be available and effective in this Policy.

Expanded Immunizations

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

OFFICE OR URGENT CARE CENTER VISITS – ILLNESS OR INJURY

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

OTHER PROFESSIONAL SERVICES

Services and supplies provided by a professional Provider are covered, subject to any specified limits as explained in the following paragraphs:

Medical Services and Supplies

Professional services, second opinions and supplies, including the services of a Provider whose opinion

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

Additionally, certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) are covered. Reimbursement for covered medical supplies may be available when these supplies are purchased new from an approved Commercial Seller, even though that seller is not a Provider. Eligible new general medical supplies purchased through an approved Commercial Seller are covered at the In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access an approved Commercial Seller and reimbursable new general medical supplies, visit Our Web site or contact Customer Service.

Professional Inpatient

Professional inpatient visits for treatment of Illness or Injury. Surgical or ancillary services (including anesthesiology, pathology, radiology, laboratory, or hospitalist services) provided by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center are covered at the In-Network benefit level. Contact Customer Service for further information and guidance.

Radiology and Laboratory

Diagnostic services and outpatient complex imaging for treatment of Illness or Injury. This includes Medically Necessary genetic testing, prostate screenings, colorectal laboratory tests and mammography services not covered under the Preventive Care and Immunizations benefit.

"Outpatient complex imaging" means:

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

Diagnostic Procedures

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

Surgical Services

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

Treatment of varicose veins is only covered when there is:

- active associated venous ulceration;
- objective documentation of persistent or recurrent bleeding from ruptured veins; or
- objective documentation of recurrent superficial phlebitis.

Therapeutic Injections

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

A selected list of Self-Administrable Injectable Medications is covered in the Prescription Medications Section.

ACUPUNCTURE
Acupuncture services provided by a Provider are covered. Acupuncture visits apply to the Maximum Benefit limit for these services, including acupuncture visits that are applied toward any Deductible.

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

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

APPROVED CLINICAL TRIALS
If an In-Network Provider is participating in an Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Schedule of Benefits. Additional specified limits are as further defined.

Definitions
The following definitions apply to this Approved Clinical Trials benefit:

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

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

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

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

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

BLOOD BANK
Services and supplies of a blood bank are covered.

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

DETOXIFICATION
Medically Necessary detoxification is covered.

DIABETIC EDUCATION
Services and supplies for diabetic self-management training and education are covered, when provided by Providers with expertise in diabetes. Diabetic nutritional counseling and nutritional therapy are covered in the Nutritional Counseling benefit.

DIALYSIS
Services and supplies for inpatient, outpatient, and home services and supplies for dialysis are covered (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

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

Reimbursement may also be available for Durable Medical Equipment when purchased new from an approved Commercial Seller, even though this entity is not a Provider. Eligible new Durable Medical Equipment purchased through an approved Commercial Seller is covered at the In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To find ways to access new Durable Medical Equipment, including how to access an approved Commercial Seller, visit Our Web site or contact Customer Service. If You choose to access new Durable Medical Equipment through Our Web site, We may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to Your Policy, but are not insurance.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)
Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations and treatment, routinely available ancillary evaluative services and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized.

"Stabilization" means to provide Medically Necessary treatment:

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

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. If services were not covered at the In-Network benefit level, contact Customer Service for further information and guidance.

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

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

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from an In-Network Provider;
- coverage is for the Insured and one companion (or two companions if the Insured is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently $50 per night for the Insured, not to exceed $100 per night for the Insured and companion(s) combined); and
- covered transportation expenses to and from the treatment area include only:
    - commercial coach class airfare;
    - commercial coach class train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

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

Coverage does not include meals or expenses outside of transportation and lodging.

HABILITATION SERVICES
Medically Necessary health care services and health care devices designed to assist a person to keep, learn or improve skills and functioning for daily living are covered. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and outpatient settings. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, and vocational or custodial services are not classified as habilitative services and are not covered under this Policy.

Habilitation services apply to the Maximum Benefit limit for these services, including habilitation services that are applied toward any Deductible. Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Habilitative Services benefit limits.

HOME HEALTH CARE
Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit. Home health care visits apply to the Maximum Benefit limit for these services, including home health care visits that are applied toward any Deductible.

Home health care furnished by duly licensed home health, hospice and home care agencies covered by this Policy 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 Insured and upon the recommendation of the Insured's attending Physician or licensed health care Provider that such care will adequately meet the Insured's needs.

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

HOSPICE CARE

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

Respite care is also covered to provide continuous care of the Insured and allow temporary relief to family members from the duties of caring for the Insured. Respite care days apply to the Maximum Benefit limit for these services, including respite care days that are applied toward any Deductible. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

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

INFUSION THERAPY

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

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

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

MATERNITY CARE

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

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

Surrogacy

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

this Policy).

You must notify Us within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with Us as needed to ensure Our ability to recover the costs of Covered Services received by You for which We are entitled to reimbursement. To notify Us, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Refer to the Right of Reimbursement and Subrogation Recovery Section for more information.

Definitions
The following definitions apply to this Maternity Care benefit:

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

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

MENTAL HEALTH SERVICES
Mental Health Services are covered for treatment of Mental Health Conditions.

Additionally, applied behavioral analysis (ABA) therapy services are covered for inpatient and outpatient treatment of autism spectrum disorders when Insureds seek services from licensed Providers qualified to prescribe and perform ABA therapy services.

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

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

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

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

NEURODEVELOPMENTAL THERAPY
Neurodevelopmental therapy services by a Physician or Practitioner are covered. Such services must be to restore and improve function based on developmental delay. Covered Services are limited to physical

therapy, occupational therapy and speech therapy. Maintenance services are covered if significant deterioration of the Insured's condition would result without the service. Neurodevelopmental therapy services apply to the Maximum Benefit limit for these services, including neurodevelopmental therapy services that are applied toward any Deductible. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

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

NUTRITIONAL COUNSELING

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

ORTHOTIC DEVICES

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

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

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

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

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

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

PALLIATIVE CARE

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

Palliative care visits apply to the Maximum Benefit limit for these services, including palliative care visits that are applied toward any Deductible. All other Covered Services for an Insured receiving palliative care remain covered the same as any other Illness or Injury.

PREVENTIVE CARE FOR SPECIFIED CHRONIC CONDITIONS

Services and supplies are covered when used to treat an Insured diagnosed with the associated chronic condition and prescribed to prevent either exacerbation of the chronic condition or the development of a secondary condition. Covered Services as specified below are not subject to any applicable Deductible for In-Network services:

- blood pressure monitor with a diagnosis of hypertension;
- hemoglobin A1c testing, and retinopathy screening with a diagnosis of diabetes;
- International Normalized Ratio (INR) testing with a diagnosis of liver disease and/or bleeding disorder;
- Low-Density Lipoprotein (LDL) testing with a diagnosis of heart disease; or
- peak flow meter with a diagnosis of asthma.

PROSTHETIC DEVICES

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, mastectomy bras only for Insureds 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 in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

RECONSTRUCTIVE SERVICES AND SUPPLIES

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

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

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

REHABILITATION SERVICES

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness, Injury or disabling condition. "Rehabilitation services" mean physical, occupational and speech therapy services necessary to help get the body back to normal health or function, and include associated services such as massage when provided as a therapeutic intervention. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

Rehabilitation services apply to the Maximum Benefit limit for these services, including rehabilitation services that are applied toward any Deductible. Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Rehabilitation Services benefit limits.

REPRODUCTIVE HEALTH CARE SERVICES

All FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services are covered, including, but not limited to:

- sterilization surgery (such as tubal ligation and vasectomy) and sterilization implants;
- implantable contraceptive devices, including insertion and removal, such as IUD copper, IUD with progestin, and implantable rods;
- contraceptive shots or injections;
- oral contraceptives (combined pill, extended/continuous use combined pill, and the mini pill);
- contraceptive products, such as condoms, vaginal rings, patches, diaphragms, sponges, cervical caps, and spermicide; and
- emergency contraceptives (such as levonorgestrel and ulipristal acetate).

We will cover up to a 12-month supply of FDA-approved contraceptive drugs from a Pharmacy or Home Delivery Supplier (may be dispensed on-site at a Provider's office, if available).

FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services are available without a prescription and no cost-sharing as explicitly described in both the Preventive Care

and Immunizations benefit and the Covered Preventive Medications provision. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptive drugs, devices, and products when not purchased at a Pharmacy. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us for processing. The Drug Claim Form may be found at https://asuris.myprime.com/v/ANH/COMMERCIAL/en/forms.html. For more information, visit Our Web site or contact Customer Service.

SKILLED NURSING FACILITY

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

Skilled Nursing Facility services apply to the Maximum Benefit limit for these services, including Skilled Nursing Facility services that are applied toward any Deductible.

SPINAL MANIPULATIONS

Spinal manipulations are covered. Manipulations of extremities are covered in the Neurodevelopmental Therapy and Rehabilitation Services benefits. Spinal manipulations apply to the Maximum Benefit limit for these services, including spinal manipulations that are applied toward any Deductible.

SUBSTANCE USE DISORDER SERVICES

Substance Use Disorder Services for treatment of Substance Use Disorder Conditions are covered, including the following:

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

Definitions

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

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

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

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

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

American Society of Addiction Medicine.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

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

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

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

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

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

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

TRANSPLANTS

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

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

For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit. Any organ or tissue which is procured outside the United States and any transplant procedure performed outside the United States are not covered.

Donor Organ Benefits

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

- selection;

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

VIRTUAL CARE

Virtual care services are covered for the use of telemedicine, telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Some Providers may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share. To learn more about how to access virtual care services or the Providers that may offer lower-cost services, visit Our Web site or contact Customer Service.

Store and Forward Services

Store and forward services are covered for primary care, urgent care, Mental Health Conditions or Substance Use Disorders as specified in the Schedule of Benefits. All other Covered Services for an Insured receiving store and forward services will be covered the same as any other Illness or Injury.

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

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

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

Telehealth

Telehealth services are covered for primary care, urgent care, Mental Health Conditions or Substance Use Disorders as specified in the Schedule of Benefits. All other Covered Services for an Insured receiving telehealth services will be covered the same as any other Illness or Injury.

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform when You are not in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider.

Telemedicine

"Telemedicine" means You are located at, and using, a Provider's office or healthcare facility's equipment for Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform. For example, telemedicine includes using the equipment at Your local Provider's office to have a live video call with a secondary Provider such as a cardiologist in a different city.

NOTE: You may receive a separate charge from the secondary Provider You contacted, in addition to the charge from the Provider's office or healthcare facility where You are physically located.

Prescription Medications

This section explains Your benefits for Prescription Medications. Benefits will be paid in this Prescription Medications benefit, not any other provision, if a medication or supply is covered by both.

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. The Drug List may be viewed on Our Web site or by contacting Customer Service.

COVERED PRESCRIPTION MEDICATIONS

Covered Prescription Medications For Treatment of Illness or Injury

Prescription Medications benefits are available for the following:

- insulin and diabetic supplies (including, but not limited to, syringes, injection aids, lancets, blood glucose monitors, test strips for blood glucose monitors, urine test strips, prescriptive oral agents for controlling blood sugar levels and glucagon emergency kits), when obtained with a Prescription Order;
- therapeutic continuous glucose monitors and related supplies that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order;
- certain insulin pumps that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order; related supplies and other insulin pumps are covered in the Durable Medical Equipment benefit;
- Prescription Medications;
- Emergency Fill five-day supply or the minimum packaging size available at the time the Emergency Fill is dispensed;
- Foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this benefit if obtained in the United States, except as may be provided under the Experimental/Investigational definition in the Definitions Section;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee;
- medications intended to treat opioid overdose that are on the Naloxone Value List found on Our Web site or by calling Customer Service;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- Self-Administrable Cancer Chemotherapy Medications;
- Self-Administrable Hemophilia Factor Drugs;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which an Insured is educated to self-inject; and
- growth hormones (if preauthorized).

Covered Preventive Medications

- certain preventive medications as recommended by the USPSTF including, but not limited to, aspirin, fluoride, iron, medications for tobacco use cessation, and pre-exposure prophylaxis (PrEP) for the prevention of HIV for people at a high risk of infection when obtained with a Prescription Order;
- all FDA-approved prescription and over-the-counter contraception methods as described under the Reproductive Health Care Services benefit;
- immunizations for adults and children according to, and as recommended by, the CDC; and
- immunizations for purposes of travel, occupation, or residency in a foreign country.

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 by the USPSTF or HRSA, or for immunizations (except for immunizations as specified in the Expanded Immunizations provision).

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 Drug List exception process at the Generic Medication payment level. For more information, visit Our Web site or contact Customer Service.

Drugs prescribed for a use other than that stated in its FDA approved labelling, commonly referred to as off-label, will be covered as any other drug subject to the Drug List.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Your Prescription Drug Rights

You have the right to safe and effective Pharmacy services. You also have the right to know what drugs are covered by Your plan and the limits that apply. If You have a question or concern about Your prescription drug benefits, please contact Us at 1 (888) 232-8229 or visit Our Web site.

If You would like to know more about Your rights, or if You have concerns about Your plan, You may contact the Washington State Office of Insurance Commissioner at 1 (800) 562-6900 or www.insurance.wa.gov. If You have a concern about the Pharmacists or Pharmacies serving You, please contact the Washington State Department of Health at 1 (360) 236-4700.

Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. We notify In-Network Providers and Participating Pharmacies which Prescription Medications require preauthorization. Prescription Medications that require preauthorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require preauthorization will not be covered until they are preauthorized. For a list of medications that require preauthorization or if You have any questions, visit Our Web site or contact Customer Service.

Drug List Changes

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

If You are taking a Prescription Medication while it is removed from the Drug List 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 drug list exception 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.

Drug List Exception Process

Non-Drug List medications are not covered by Your Prescription Medications benefit. However, a Prescription Medication not on the Drug List may be covered in certain circumstances.

"Non-Drug List" means those self-administered Prescription Medications not listed on the Drug List.

To request coverage for a Prescription Medication not on the Drug List, You or Your Provider will need to request preauthorization so that We can determine that a Prescription Medication not on the Drug List is Medically Necessary. Your Prescription Medication not on the Drug List may be considered Medically Necessary if:

- medication policy criteria are met, if applicable;
- You are not able to tolerate a covered Prescription Medication(s) on the Drug List;
- Your Provider determines that the Prescription Medication(s) on the Drug List is not therapeutically effective for treating Your covered condition; or
- Your Provider determines that a dosage required for effective treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our Web site. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on Our Web site. You or Your requesting Provider will be notified of Our determination no later than 72 hours following receipt of the

request. If You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Drug List medication, You or Your requesting Provider will be notified of Our determination no later than 24 hours following receipt of the request.

Once preauthorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your benefit and will apply toward any Deductible or Out-of-Pocket Maximum.

If preauthorization has not been approved for Your request, You have the right to appeal. Refer to the Appeal Process Section for more information on how to initiate an Appeal request.

The Drug List exception process may also be used to substitute a covered Prescription Medication for another drug on the Drug List if:

- You do not tolerate the covered Drug List medication; or
- Your Provider determines that the covered Drug List medication is not therapeutically efficacious for treating Your covered condition.

Emergency Fill

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

- the dispensing Pharmacy cannot reach Our prior authorization department by phone as it is outside of business hours; or
- We are available to respond to phone calls from a dispensing Pharmacy regarding a covered benefit, but cannot reach the prescriber for a full consultation.

Your Responsibility for Cost Differences of Chosen Medications

You will be responsible for the applicable Copayment and/or Coinsurance for the Brand-Name Medication or Specialty Medication at the time of purchase. You will also be responsible for paying excess costs above Your applicable cost-share if either of the following occur:

- if You choose to fill a Prescription Order with a Brand-Name Medication and an equivalent Generic Medication is available, You will be responsible for paying the difference in cost; or
- if You choose to fill a Prescription Order with a Specialty Medication and a Specialty Biosimilar Medication is available, You will be responsible for paying the difference in cost.

The excess in cost does not apply toward any Deductible or any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication or the Specialty Medication must be dispensed, You will still be responsible for the excess in cost.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on Our Web site or by contacting Customer Service. There are more than 1,200 Participating Pharmacies in Our Washington State network from which to choose.

You must present Your identification card to identify Yourself as Our Insured when obtaining Prescription Medications from a Pharmacy or Home Delivery Supplier. If You do not present Your identification card You may be charged more than the Covered Prescription Medication Expense.

Claims Submitted Electronically

Participating Pharmacies will submit claims electronically.

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, complete a Prescription Medication claim form and mail a copy of

the form and the Prescription Medication receipt to Us. To find the Prescription Medication claim form, visit Our Web site or contact Customer Service.

We will reimburse You directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Coinsurance required.

Home Delivery (Mail-Order)

You can use home delivery services to purchase covered Prescription Medications. Home delivery coverage applies when Prescription Medications are purchased from a Home Delivery Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Home Delivery Suppliers.

To buy Prescription Medications through the mail, send all of the following items to the Home Delivery Supplier at the address shown on the prescription mail-order form (which also includes refill instructions) available on Our Web site:

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

Prescription Medications Dispensed by Excluded Pharmacies

We do not permit excluded Pharmacies to submit claims after the excluded Pharmacies have been added to the Office of the Inspector General (OIG) list. A Pharmacy may be excluded if it has been investigated by the OIG and appears on the OIG's exclusion list.

You will be notified if You are receiving medications from a Pharmacy that is later determined to be an excluded Pharmacy so that You may obtain future Prescription Medications from a non-excluded Pharmacy. Up to the time of notification, Your previously submitted claims will still be processed.

Refills

Refills obtained from:

- a Pharmacy are covered when You have taken 75 percent of the previous prescription or 70 percent of the previous topical ophthalmic prescription;
    - except, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.
- a Pharmacy or Home Delivery Supplier for refills of FDA-approved contraceptive drugs are covered for up to a 12-month supply;
- a Home Delivery Supplier are covered after You have taken all but 20 days of the previous Prescription Order (except for FDA-approved contraceptive drugs).

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.

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

Discounts or Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon will apply toward Your Deductible and Out-of-Pocket Maximum, unless there is a generic or therapeutic equivalent on Our Drug List. However, if there is a generic or therapeutic equivalent on Our Drug List, the reduction to Your cost-sharing will still apply toward Your Deductible and Out-of-Pocket Maximum if the

Prescription Medication was obtained through the Drug List exception process or step therapy (preauthorization). For more information, visit Our Web site or contact Customer Service.

LIMITATIONS

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

Prescription Medication Supply Limits

- **30-Day Supply Limit:**
  - **Specialty Medications** – the largest allowable quantity for a Specialty Medication is a 30-day supply. The first fill is allowed at a Pharmacy. Additional fills must be purchased from a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, visit Our Web site or contact Customer Service. Specialty medications are not allowed through Home Delivery Suppliers.
- **90-Day Supply Limit:**
  - **Participating Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Participating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
  - **Home Delivery (Mail-Order) Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Multiple-Month Supply** – the maximum number of days for a covered Prescription Medication that is packaged in a multiple-month supply and is purchased from a Participating Pharmacy is a 90-day supply (even if the manufacturer packaging includes a larger supply). The Copayment and/or Coinsurance is based on the Prescription Order up to a 34-day supply within that multiple-month supply.
- **Maximum Quantity Limit**
  - For certain Prescription Medications, We establish maximum quantities other than those listed in the Schedule of Benefits. 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 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 identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.
  - For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Insured's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
  - Any amount over the established maximum quantity is not covered, except if 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.

EXCLUSIONS

The following exclusions apply to this Prescription Medications Section and are not covered:

Biological Sera, Blood or Blood Plasma

Bulk Powders

Except as included on Our Drug List and presented with a Prescription Order, bulk powders are not covered.

Cosmetic Purposes

Prescription Medications used for cosmetic purposes, including, but not limited to:

- removal, inhibition or stimulation of hair growth;
- anti-aging;
- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

Devices or Appliances
Except as provided in the Medical Benefits Section, devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents
Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Digital Therapeutics
Except as included on Our Drug List and presented with a Prescription Order, digital therapeutics are not covered.

Foreign Prescription Medications
Except for the following, foreign Prescription Medications are not covered:

- Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States; or
- Prescription Medications You purchase while residing outside the United States.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics
Except as provided in the Medical Benefits Section, general anesthetics are not covered.

Insulin Pumps and Pump Administration Supplies
Except as provided in the Durable Medical Equipment benefit, insulin pumps and supplies are not covered.

Medical Foods
Except as provided in the Medical Benefits Section, medical foods are not covered.

Medications that are Not Considered Self-Administrable
Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications
Except for the following, nonprescription medications that by law do not require a Prescription Order are not covered:

- medications included on Our Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

- over-the-counter medications;
- vitamins;
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed by this benefit if obtained from a Pharmacy.

Prescription Medications for the Treatment of Infertility

Prescription Medications Found to be Less than Effective under Drug Efficacy Safety Implementation (DESI)

Prescription Medications Not Approved by the FDA

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

Prescription Medications Not on the Drug List
Except as provided through the Drug List Exception Process, Prescription Medications that are not on the Drug List are not covered.

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

Prescription Medications without Examination
Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS
The following definitions apply to this Prescription Medications Section:

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

Drug List means Our list of selected Prescription Medications. We established Our Drug List and We review and update it routinely. It is available on Our Web site or by calling Customer Service. Medications are reviewed and selected for inclusion on Our Drug List by an outside committee of Providers, including Physicians and Pharmacists.

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

prior authorization.

Home Delivery Supplier means a home delivery (mail-order) Pharmacy with which We have contracted for home delivery (mail-order) services.

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. To find a Participating Pharmacy, visit Our Web site or contact Customer Service.

Participating Specialty Pharmacy means a Specialty Pharmacy with which We have a contract or a Specialty Pharmacy that participates in a network for which We have contracted to have access.

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

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

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

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

Preferred Specialty Medications and Specialty Medications means medications that may be used to treat complex conditions, including, but not limited to:

- multiple sclerosis;
- rheumatoid arthritis;
- cancer;
- clotting factor for hemophilia or similar clotting disorders; and
- hepatitis C.

Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit Our Web site or contact Customer Service.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or
- are specifically included on Our Drug List.

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

Self-Administrable Prescription Medications, Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication means a Prescription Medication labeled by the manufacturer as intended to be safely administered by You or Your caregiver outside a

medically supervised setting (such as a Hospital, Physician's office or clinic). Self-Administrable Cancer Chemotherapy Medications include oral Prescription Medications used to kill or slow the growth of cancerous cells. Information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability is used to determine a Self-Administrable Medication. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Biosimilar Medication means an FDA-approved Prescription Medication that has a biological similarity to a Specialty Medication. The Specialty Biosimilar Medication is identical in function to the comparable Specialty Medication and may be more cost efficient. Similar to the FDA's requirements for a generic equivalent, a Specialty Biosimilar Medication must meet the same manufacturing and testing standards, and must be as safe and effective as the comparable Specialty Medication.

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit Our Web site or contact Customer Service.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Drug List that is approved for coverage at the Brand-Name Medication benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Specialty Medication benefit level.

Pediatric Vision Services

Vision Services are covered for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the month in which the Insured turns 19 years of age. Benefits will be paid in this Pediatric Vision Services benefit, not any other provision, if a service or supply is covered by both.

This pediatric vision coverage is provided by Us, in collaboration with Vision Service Plan (VSP), which coordinates the pediatric vision benefits and associated claims processing. VSP is a separate company that provides vision benefit services.

VISION EXAMINATION

Routine vision screening and comprehensive eye examination services are covered, including:

- refraction;
- dilation as professionally indicated;
- prescribing and ordering proper lenses;
- verifying the accuracy of the finished lenses; and
- progress or follow-up work as necessary.

VISION HARDWARE

Hardware including frames, contacts and lenses is covered, subject to any specified limits as explained in the following paragraphs:

Frames

One frame from a VSP Doctor is available per Calendar Year. However, for the VSP Doctor benefit level, frames are limited to the Otis & Piper Eyewear Collection.

Lenses

One pair of standard lenses is covered (in glass, plastic or polycarbonate) for one of the following:

- single vision;
- lined bifocal;
- lined trifocal;
- lenticular;
- photochromic lenses;
- elective contacts; or
- Necessary Contact Lenses.

Any of the following lens enhancements:

- scratch coating;
- UV (ultraviolet) protection; and
- tinting.

Contacts are available once per Calendar Year instead of all other lenses and frames. When You receive contact lenses, You will not be eligible for any lenses and/or frames again until the next Calendar Year. An annual supply of Necessary Contact Lenses, including disposable lenses for monthly, bi-weekly, or daily use, is covered if You have a specific condition for which contact lenses provide better visual correction.

If You choose non-Medically Necessary contact lenses instead of glasses, one of the following elective contact lens types may be chosen:

- standard (one pair annually);
- monthly (six-month supply);
- bi-weekly (three-month supply); or
- dailies (three-month supply).

CONTACT LENS EVALUATION AND FITTING EXAMINATION

One contact lens evaluation and fitting examination, including follow-up care, is also covered per Calendar Year.

LOW VISION BENEFIT

Low vision benefits for Insureds are covered, including optical devices (such as high power spectacles, magnifiers, telescopes), aids, annual comprehensive low vision examinations and follow-up visits if vision loss is sufficient enough to prevent reading and performing daily activities. Consult Your VSP Doctor for more details. Covered Services include professional services and ophthalmic materials, subject to any specified limits as explained in the following paragraphs:

Supplemental Examinations (Testing)

Supplemental examinations (complete low vision testing, analysis and diagnosis) which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or low vision aids where indicated.

Supplemental Aids

Low vision aids, including, but not limited to:

- optical;
- non-optical; and
- associated training.

DISCOUNTS FROM VSP DOCTORS

Discounts are available for the following services or supplies when received from a VSP Doctor:

- when You receive a complete pair of glasses, You are entitled to receive a 20 percent discount on non-covered materials;
- You are entitled to receive a 15 percent discount on contact lens examination services, beyond the covered vision examination; and
- VSP Doctors may request an additional vision examination at a discount within 12 months if necessary.

Discounts are applied to the VSP Doctor's usual and customary fees and are unlimited for 12 months on or following the date of the patient's last eye examination.

Discounts do not apply to:

- vision care benefits obtained from Out-of-Network Providers; or
- sundry items, including, but not limited to:
    - contact lens solutions;
    - cases;
    - cleaning products; or
    - repairs of spectacle lenses or frames.

THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.

PEDIATRIC VISION CLAIMS AND REIMBURSEMENT

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment.

Concerns about Claim Denial or Other Action

If You have a concern regarding a claim denial or other action in these Pediatric Vision Services benefits and wish to have it reviewed, You may Appeal. See the Appeal Process for a description of the process for Appeals. Additionally, if you have questions regarding reimbursement and subrogation recovery, see the Right of Reimbursement and Subrogation Recovery Section.

EXCLUSIONS

The following exclusions apply to this Pediatric Vision Services Section and are not covered:

Certain Contact Lens Expenses
- artistically-painted or non-prescription contact lenses;
- contact lens modification, polishing or cleaning;
- refitting of contact lenses after the initial (90-day) fitting period;
- additional office visits associated with contact lens pathology; and
- contact lens insurance policies or service agreements.

Corneal Refractive Therapy (CRT)
Reversals or revisions of surgical procedures which alter the refractive character of the eye, including orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Lens Enhancements
Except as provided in the Vision Hardware benefit, lens enhancements are not covered, including, but not limited to:

- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses; or
- standard, premium and custom progressive multifocal lenses.

Medical or Surgical Treatment of the Eyes
Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Orthoptics or Vision Training
Except as provided in the Low Vision benefits, orthoptics, vision training and any associated supplemental testing are not covered.

Plano Lenses (Less Than a ± .50 Diopter Power)

Replacements
Replacement of any lost, stolen or broken lenses and/or frames.

Two Pair of Glasses in Lieu of Bifocals

DEFINITIONS
The following definitions apply to this Pediatric Vision Services Section:

Allowed Amount means:

- For VSP Doctors, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers, the amount determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services.

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

Benefit Authorization means VSP has approved benefits for You.

Experimental Nature means a procedure or lens that is not used universally or accepted by the vision care profession.

Necessary Contact Lenses means contact lenses that are prescribed by Your VSP Doctor or Out-of-Network Provider for other than cosmetic purposes. Benefit Authorization is not required for You to be eligible for Necessary Contact Lenses, however, certain benefit criteria, as defined by VSP, must be satisfied in order for contact lenses to be covered as Necessary Contact Lenses.

Out-of-Network Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care Provider who has not contracted with VSP to provide vision care services and/or vision care materials.

Vision Service means those vision-related services, supplies, treatment or accommodation provided for the diagnosis or correction of visual acuity. These services must be received from a Physician or optometrist practicing within the scope of their license.

VSP Doctor means a Physician or Practitioner (for example, an ophthalmologist or optometrist) who is duly licensed and who has contracted with VSP to provide vision care services and/or vision care materials to Insureds in accordance with the provisions of this coverage. The Provider Network for a VSP Doctor is identified on the Schedule of Benefits.

Pediatric Dental Services

Dental Services are covered for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the month in which the Insured turns 19 years of age. Benefits will be paid in this Pediatric Dental Services benefit, not any other provision, if a service or supply is covered by both.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Preventive and diagnostic Dental Services are covered, subject to any specified limits as explained in the following:

- bitewing x-rays, limited to two sets (four x-rays total) 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;
- cleanings, limited to two per Calendar Year (a third cleaning may be covered during the same Calendar Year for Insureds with a diagnosis of one or more of the following: pregnancy, diabetes, coronary atherosclerosis, and hypertensive heart disease);
- diagnostic casts when Dentally Appropriate;
- limited oral evaluations to evaluate the Insured for a specific dental problem or oral health complaint, dental emergency or referral for other treatment;
- visual oral assessments or screenings, not performed in conjunction with other clinical oral evaluation services, limited to two per Calendar Year;
- occlusal intraoral x-rays, limited to once in a two-year period;
- oral hygiene instruction, limited to two sessions per Calendar Year, 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 Calendar Year;
- problem focused oral examinations;
- panoramic mouth x-rays, limited to one in a three-year period;
- sealants, limited to permanent bicuspids and molars;
- topical fluoride application, limited to three applications per Calendar Year. Additional topical fluoride applications are covered when determined Dentally Appropriate; and
- space maintainers (fixed unilateral or fixed bilateral) includes:

    - re-cementation of space maintainers;
    - removal of space maintainers; and
    - replacement space maintainers are covered when Dentally Appropriate.

BASIC DENTAL SERVICES

Basic Dental Services are covered, subject to any specified limits as explained in the following:

- Complex oral surgery procedures including surgical extractions of teeth, impactions, alveoloplasty, frenulectomy, frenuloplasty, vestibuloplasty and residual root removal.
- Emergency treatment for pain relief.
- Endodontic services consisting of:

    - apexification for apical closures of anterior permanent teeth;
    - apicoectomy;
    - retrograde filling for anterior teeth;
    - 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:

  - five surfaces per tooth for permanent posterior teeth, except for upper molars;
  - six surfaces per tooth for teeth 1, 2, 3, 14, 15 and 16;
  - 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 1, 2, 3, 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 Insured's health. 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), once per quadrant in a five-year period;
  - debridement;
  - gingivectomy and gingivoplasty, once per quadrant in a three-year period;
  - periodontal maintenance, once per quadrant in a Calendar Year; and
  - scaling and root planing, once per quadrant in a two-year period.

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

MAJOR DENTAL SERVICES

Major Dental Services are covered, subject to any specified limits as explain in the following:

- Adjustment and repair of dentures and bridges:

  - adjustments within 90 days of delivery (placement) will not be separately reimbursed;
  - the cost of repairs cannot exceed the cost of a replacement denture or a partial denture; and
  - additional repairs on a case-by-case basis and when prior authorized.

- Behavior management.
- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement.
- Crowns and core build-ups, limited to the following:

  - an indirect crown, for permanent anterior teeth, one per tooth in a five-year period;
  - 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;
  - stainless steel crowns for primary anterior and posterior teeth, once in a three-year period; and
  - stainless steel crowns for permanent posterior teeth (excluding teeth 1, 16, 17 and 32), once in a three-year period.

- Dental implant crown and abutment related procedures, limited to one per tooth in a seven-year period.

- Dentures, full and partial, including:
  - adjustment and repair of dentures and bridges, limited to one per arch in a 12-month period;
  - denture rebase, limited to one per arch in a three-year period, if performed at least six months from the seating date;
  - denture relines, limited to one 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 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 Insureds 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.
- Post-surgical complications.
- Repair of crowns, limited to one per tooth per Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Lifetime.

PEDIATRIC DENTAL CLAIMS AND REIMBURSEMENT

In-Network Dentist Claims and Reimbursement

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

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

EXCLUSIONS

The following exclusions apply to this Pediatric Dental Services Section and are not covered:

Aesthetic Dental Procedures

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

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 the following, cosmetic and/or reconstructive services and supplies are not covered:

- Dentally Appropriate services and supplies to treat a congenital anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

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

"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:

- endodontic endosseous implants;
- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lifts;
- 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
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies are not covered, except as explicitly provided in the Pediatric Dental Services section.

Non-Emergency Services While Outside of the United States

Occlusal Treatment
Services and supplies provided in connection with dental occlusion, including occlusal analysis and adjustments are not covered, except as explicitly provided in the Pediatric Dental Services section.

Oral Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means 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
Services and supplies provided in connection with orthodontics are not covered, except as explicitly provided in the Pediatric Dental Services section, including:

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

Precision Attachments

Prosthesis
Services and supplies provided in connection with dental prosthesis, including the following:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting

Replacements
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 are not covered, except as explicitly provided in the Pediatric Dental Services section.

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

- 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;
- 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; and
- 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, except as explicitly provided in the Medical Benefits Section.

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
The following definitions apply to this Pediatric Dental Services Section:

Allowed Amount means:

- For In-Network Dentists, the amount that they have contractually agreed to accept as payment in full for Covered Services.

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, contact Customer Service.

Dentally Appropriate means a Dental Service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and is 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 Insured's condition; and

- not primarily for the convenience of the Insured, Insured's Family or Provider.

A dental service may be dentally appropriate yet not be a covered service in this Policy.

Dentist means an individual who is duly licensed to practice dentistry in all of its branches (including a doctor of medical dentistry, doctor of dental surgery or a denturist) or to practice as a dental hygienist who is permitted by their respective state licensing board, to independently bill third parties.

In-Network Dentist means a contracted Dentist in Your Provider network who provides services and supplies to Insureds in accordance with the provisions of this coverage. The Provider network for an In-Network Dentist is identified on the Schedule of Benefits.

Out-of-Network Dentist means a Dentist who is not in Your Provider network.

General Exclusions

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

SPECIFIC EXCLUSIONS

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

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

Activity Therapy

The following activity therapy services are not covered:

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

Adventure, Outdoor, or Wilderness Interventions and Camps

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

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

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

Assisted Reproductive Technologies

Assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to:

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

Aviation
Except for an injured Insured that is a passenger on a scheduled commercial airline flight or air ambulance, services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing) are not covered.

Certain Therapy, Counseling and Training
Except as provided in the Individual Assistance Program (IAP), the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling; and
- job skills or sensitivity training.

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

Conditions Incurred in or Aggravated During Performances in the Uniformed Services
The treatment of any Insured'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.

Continuous Glucose Monitors
Except as provided in the Prescription Medications Section, continuous glucose monitors (whether therapeutic or non-therapeutic) are not covered.

Cosmetic Services and Supplies
"Cosmetic" means services or supplies that are applied to normal structures of the body primarily to improve or change appearance. This exclusion does not apply to services that are prescribed as Medically Necessary for Gender Affirming Treatment and are in accordance with accepted standards of care.

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

Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

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

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

Family Counseling
Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

Family Planning
Over-the-counter contraceptive supplies, except as covered under the Reproductive Health Care

Services benefit.

Fees, Taxes, Interest
Except as required by law or as outlined in the Durable Medical Equipment benefit, the following fees, taxes and interest are not covered:

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

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

Additionally, except as listed below, government facilities or government facilities outside the Service Area are not covered:

- as required by law for emergency services.

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

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- Mental Health Conditions;
- Substance Use Disorders; or
- for anesthesia purposes.

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by an Insured's voluntary participation in an activity where the Insured is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility drugs; and

- other medications associated with fertility treatment.

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

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

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

Liposuction for the Treatment of Lipedema

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 this Policy once Your claims are no longer covered by that carrier.

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

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

Non-Emergency Services While Outside of the United States

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

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

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

- temporomandibular joint disorder;
- orthognathic surgery due to an Injury;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- congenital anomalies.

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

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

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

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

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

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

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

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

Routine Foot Care

Routine Hearing Examinations

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

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

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

"Immediate family" means:

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

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

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an

employer or primarily for administrative or qualification purposes are not covered.

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

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

Sexual Dysfunction
Except as provided in the Mental Health Services benefit, treatment, services and supplies are not covered for or in connection with sexual dysfunction regardless of cause.

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

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

Travel and Transportation Expenses
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

Varicose Vein Treatment
Except as provided in the Other Professional Services benefit, treatment of varicose veins is not covered.

Vision Care
Except as provided in the Pediatric Vision Services Section, vision care services are not covered, including, but not limited to:

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

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

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

If an Illness or Injury could be considered work-related, an Insured will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

Policy and Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

In-Network Provider Claims and Reimbursement

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

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

Out-of-Network Provider Claims and Reimbursement

In order for 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;
- the patient's name; and
- the Policyholder's identification number.

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.

Our standard policy is to make payment for Out-of-Network Provider claims directly to the Provider or, with submission of sufficient documentation that the Insured has already "paid in full," solely to the Insured.

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

Timely Filing of Claims

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

Claim Determinations

Within 30 days of Our receipt of a claim, We will notify You of Our action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. We will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.

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

PRIOR APPROVAL OF OUT-OF-NETWORK PROVIDERS

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

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

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

CONTINUITY OF CARE

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

To qualify for continued coverage, You must be:

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

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

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 Policyholder or any 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 the experience of the pool by which You are 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 Right of Reimbursement and Subrogation Recovery provision for additional information.

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.

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

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

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

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

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

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

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

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

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

- By accepting benefits under this plan, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a

claim to recover damages or obtain compensation due to Third Party Injuries sustained by You.

- You or Your representative agrees to cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Policy. In addition, You or Your representative agrees to do nothing to prejudice Our subrogation and reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible Third Party, We may advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the Third Party in trust for Us, 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 serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to the plan's right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- Further, You or Your representative give Us a lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by law to the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- You or Your representative also agrees to pay from any recovery, settlement, judgment or other source of compensation, any and all amounts due Us as reimbursement for the full cost of all benefits, to the extent permitted by law, associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Illness or Injury 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 Illness or Injury for which We have provided benefits. This is true regardless of whether:

    - the Third Party or the Third Party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the Third Party recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Policy. 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.

We may recover to the extent permitted by law, the full cost of all benefits paid by this plan under this Policy without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. You may incur attorney's fees and costs in connection with obtaining recovery. If this Policy 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 Policy 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. In the event You or Your representative fail to cooperate with Us, You shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Us in obtaining repayment.

No-Fault Coverage

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

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorist insurance. When We use the term motor vehicle insurance below, it includes medical expense coverage, personal injury protection coverage, uninsured motorist coverage, underinsured motorist coverage or any coverage similar to any of these coverages. Benefits for health care expenses are excluded under this Policy if You receive payments from uninsured motorist coverage or underinsured motorist coverage for such expenses to the extent those payments exceed the amount necessary to fully compensate You, along with all other payments You receive to compensate You for Your Injuries, losses or damages, for those Injuries, losses or damages.

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

- If a claim for health care expenses arising out of a motor vehicle accident is filed with 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 Right of Reimbursement and Subrogation Recovery 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 Policy. The only exception would be if You or one of Your eligible dependents are exempt from state or federal workers' compensation law.

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

- You must notify 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 Right of Reimbursement and Subrogation Recovery provision.

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining recovery. If this Policy 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 Policy 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 this Policy 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 this Policy 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. When the Primary Plan is Medicare and This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the Medicare Allowable Expense. 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.

When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

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

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

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

Order of Benefit Determination Rules

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

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

- For a child whose parents are married or are living together, whether or not they have ever been married:
  - The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
  - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
- For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the child's health care expenses

or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree. If benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next policy year;

- If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
- If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

  The Plan covering the Custodial Parent, first;

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

  The Plan covering the noncustodial parent, third; and then

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

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

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

COBRA or State Continuation Coverage. If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law 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 30 calendar days.

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

To avoid delays in claims 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 You have questions about this Coordination of Benefits provision, contact the Washington State Insurance Department.

Appeal Process

We have delegated the Appeals process for pediatric vision benefits to VSP, though We retain ultimate responsibility over the Appeals process. The terms "We," "Us" and "Our" in this Appeal Process Section refer to VSP. Appeals can be initiated through either a written or verbal request. A verbal Appeal request can be made by calling VSP. A written Appeal request can be made by:

- completing the form available on **www.vsp.com;** or
- mailing the form to VSP at: Attn: Complaint and Grievance Unit, Vision Service Plan Insurance Company, P.O. Box 997100, Sacramento, CA 95899-7100.

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under this Policy and wish to have it reviewed, You may Appeal. There is one level 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, refer to the Grievance Process.

APPEALS

Appeals can be initiated through either written or verbal request. A verbal Appeal request can be made by calling Customer Service. A written Appeal request can be made by:

- completing the form available on **asuris.com**;
- submitting the form via e-mail to MemberAppeals@asuris.com;
- submitting the form via fax to 1 (888) 496-1542; or
- mailing the form to Us at: Attn: Member Appeals, Asuris Northwest Health P.O. Box 1408, Lewiston, ID 83501.

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 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. 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. An Adverse Benefit Determination may be overturned by Us at any time during the Appeal process if We receive newly submitted documentation and/or information which establishes coverage, or upon the discovery of an error, the correction of which would result in overturning the Adverse Benefit Determination.

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 Appeals

Internal Appeals, including internal Expedited 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.

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (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. You will also be provided five business days to submit, in writing, any additional information to the IRO. 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 time frames 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 reviews of Adverse Benefit Determinations (meaning the reviews will be done simultaneously). When concurrent expedited reviews are 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 employees who 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 time frame) 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 48 hours 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, contact Customer Service, or write to Customer Service at the following address: Asuris Northwest Health, MS CS B32B, P.O. Box 1827, Medford, OR, 97501-9884. If you have any questions about the VSP Appeal process, You may contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. to 8 p.m., Saturday 7 a.m. to 8 p.m., and Sunday 7 a.m. to 7 p.m.

DEFINITIONS

The following definitions apply to this Appeal Process Section:

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 Insured'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 an Insured or, if authorized by the Insured, the Insured'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 an Insured 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 time frames 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 Asuris Northwest Health's Internal Appeal decisions are correct.

Independent Review Organization (IRO) is an independent Physician review organization that acts as the decision-maker for External Appeals and External Expedited Appeals and that is not controlled by Us.

Internal Appeal means a review and reconsideration of an Adverse Benefit Determination performed by Asuris Northwest Health.

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

Pre-Service means any claim for benefits 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 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 Appeal. No authorization is required from the parent(s) or legal guardian of an Insured who is a 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 without additional authorization. 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.

ASSISTANCE

For assistance with internal claims and Appeals and the external review process, 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**

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 Customer Service at 1 (888) 232-8229 or write to Customer Service at the following address: Asuris Northwest Health, MS CS B32B, P.O. Box 1827, Medford, OR, 97501-9884.

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, request one at the time of submission.

For any complaints involving an Adverse Benefit Determination, refer to the Appeals Process Section.

DEFINITIONS
The following definitions apply to this Grievance Process Section:

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.

Representative means someone who represents You for the Grievance. 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 Grievance. No authorization is required from the parent(s) or legal guardian of an Insured who is a dependent child and is less than 13 years old. 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. If no authorization exists and is not received, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Eligibility and Enrollment

This section explains the terms of eligibility under this Policy for a Policyholder and any eligible dependents. It describes when coverage under this Policy begins for You and/or Your eligible dependents. Payment of any corresponding monthly premium is required for coverage to begin on the indicated dates.

WHEN COVERAGE BEGINS

You must complete an application for coverage for Yourself and Your eligible dependents or enroll through the Washington Health Benefit Exchange (HBE). Subject to meeting the eligibility requirements as stated in the following paragraphs, coverage for You and Your applying eligible dependents will begin on the first day of the month (provided that the application is received on or prior to the 15th of the previous month) following receipt and acceptance of the application by Us, except as required otherwise by the Special Enrollment provision. If You enrolled through the HBE, coverage will begin as of the Effective Date determined by the HBE.

Residency Requirement

A Policyholder must reside in Our Service Area (and not elsewhere) and continue to live in Our Service Area six months or more per Calendar Year. We routinely verify the residence of Our applicants. Whether enrolling with Us or through the HBE, We may require You to provide Us with a copy of the following to verify Your current residency status:

- A current utility bill containing both service and mailing addresses;
- if You are a student, a letter from the college/university registrar noting Your local residence address; or
- alternate documentation as authorized by Us.

For the purpose of maintaining this Policy, You must maintain a fixed permanent home within the Service Area. If it is necessary for the Policyholder to leave the Service Area for an extended period of time, the Policyholder may be required to submit appropriate documentation as proof of maintaining their primary residence within the Service Area during their absence. Medical treatment within the Service Area does not establish residency.

You must promptly notify Us if You move and are no longer a Resident in Our Service Area. We will terminate this Policy and refund any premium payments made for periods after the end of the billing cycle in which We acquire actual knowledge that You are no longer a Resident. The only exception to the termination policy is if You are a military service member who is stationed outside of Our Service Area, You will not be terminated if Your legal residence continues to be within Our Service Area.

Policyholder

An applicant must agree to the terms of this Policy by submitting a written application for approval and acceptance by Us. The application will be a part of this Policy. Applicants are eligible to apply for this Policy if they are not enrolled in Medicare and meet the Residency Requirement as stated above at the time of application for enrollment. Applications and statements made on the application will be binding on both the applicant and dependents.

Dependents

Your Enrolled Dependents are eligible for coverage when You have listed them on the application or on subsequent change forms and when We have enrolled them in coverage under this Policy, or when You have completed the HBE enrollment process. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your domestic partner.
- 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, stepchild, 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; or
- 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) child who is age 26 or over and incapable of self-support because of developmental or physical disability that began before the child's 26th birthday. You must 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, the child meets the requirements of a Disabled Dependent as defined in the Definitions Section below, and either:

  - the child is an enrolled child immediately before their 26th birthday; or
  - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as Your dependent on group coverage or an individual plan issued by Us since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site or by calling Customer Service. We may request an annual update on the child's disability following the dependent's 28th birthday. If enrolling through the HBE, contact the HBE for additional information on enrolling Disabled Dependents.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an application to Us or through application to the HBE. Applications 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. Applications 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 the Effective Date. 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 this Policy will be provided for a newborn child for up to 21 days following birth when delivery of the child is covered under this Policy. 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 this Policy. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn.

SPECIAL ENROLLMENT

You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll (except as specified otherwise below) for coverage under this Policy outside of the open enrollment period if one of the following qualifying events is met:

- You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption, or Placement for Adoption;
- You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- Unintentional, inadvertent, or erroneous enrollment or non-enrollment resulting from an error, misrepresentation, or inaction by an officer, employee, or agent of the HBE or U.S. Department of Health and Human Services;
- You and/or Your eligible dependents can adequately demonstrate that a qualified health plan has substantially violated a material provision of its contract with regard to You and/or Your eligible dependents;
- You become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;

- Loss of eligibility for group coverage due to: death of a covered employee, an employee's termination of employment (other than for gross misconduct), an employee's reduction in working hours, an employee's divorce or legal separation, an employee's entitlement to Medicare, a loss of dependent child status, or certain employer bankruptcies;
- Loss of coverage as the result of termination of a domestic partnership;
- Newly gain access to an individual coverage health reimbursement arrangement (ICHRA) or are newly provided a qualified small employer health reimbursement arrangement (QSEHRA);
- Permanent change of residence, work, or living situation such that a health plan by which You were covered does not provide coverage in Your new service area;
- The plan by which You were covered no longer offers benefits to the class of similarly situated individuals that includes You;
- The HBE terminates Your qualified health plan coverage pursuant to 45 CFR 155.430 and any applicable 3-month grace period expires;
- Exhaustion of COBRA coverage due to failure of the employer to remit premium;
- Loss of COBRA coverage by exceeding the lifetime limit and no other COBRA coverage is available;
- Discontinuation of high-risk pool coverage;
- Loss of eligibility for Medicaid or a public program providing health benefits;
- Permanent move resulting in new eligibility for a previously unavailable plan;
- Permanently move to a new service area;
- Loss of minimum essential coverage, including because an age is reached at which dependent status ends or because an employer stops contributing toward group coverage;
- If enrolled through the HBE, other exceptional circumstances as the HBE may provide; or
- If enrolled through the HBE, an individual, not previously lawfully present, gains status as a citizen, national, or lawfully present individual in the U.S.

Note that a qualifying event due to loss of minimum essential coverage does not include a loss because You failed to timely pay Your portion of the premium on a timely basis (including COBRA) or when termination of such coverage was because of rescission. It also doesn't include Your decision to terminate coverage.

For the above qualifying events, Your completed application must be submitted within 60 days of the qualifying event. Coverage will be effective no later than the first of the calendar month following the date of the qualifying event; however, when the qualifying event is a child's birth, adoption, or Placement for Adoption, coverage is effective from the date of the birth, adoption or placement.

If enrolling through the HBE, and You are classified as an "Indian" under federal law, You may move between qualified health plans one time per month.

OPEN ENROLLMENT PERIOD

Open enrollment is a specific period of time each Calendar Year during which enrollment under this Policy is open to all who qualify. The dates of the open enrollment period are established by the HBE. Refer to the HBE for the most current open enrollment dates.

DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent in this Policy.

DEFINITIONS

The following definitions apply to this Eligibility and Enrollment Section:

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.

Resident means a person who is able to provide satisfactory proof of having residence within the Service Area as their primary place of domicile for six months or more in a Calendar Year, for the purpose of being an eligible applicant.

Disabled Dependent means a child who is and continues to be both:

- incapable of self-sustaining employment by reason of developmental or physical disability; and
- chiefly dependent upon the Policyholder for support and maintenance.

When 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. If You enrolled through the HBE, coverage will end as of the date determined by the HBE.

No person will have a right to receive any benefits after the date coverage is terminated. Termination of Your or Your Enrolled Dependent's coverage under this Policy 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 this Policy was in effect.

GUARANTEED RENEWABILITY AND POLICY TERMINATION

This Policy is guaranteed renewable, at Your option, upon payment of the monthly premium when due or within the grace period, except that We may terminate this Policy or the coverage for an individual, for any one of the following reasons:

- Nonpayment of the premium by the end of the grace period (see also the Nonpayment of Premium and Grace Period provisions below).
- Violation of Our published policies that have been approved by the Washington State Insurance Commissioner, if any.
- Insureds who fail to pay the Deductible or Copayment amount owed to Us and not the Provider of health care services.
- For fraud or intentional misrepresentation of material fact by the Insured (see also the Other Causes of Termination provision below).
- Insureds who materially breach this Policy.
- There is a change or implementation of federal or state laws that no longer permits the continued offering of this Policy.
- There is zero enrollment on the product.

In the event We eliminate the coverage described in this Policy for the Policyholder and all Enrolled Dependents on their renewal dates, We will provide 90-days written notice to all Insureds covered by this Policy. We will make available to the Policyholder, on a guaranteed issue basis and without regard to the health status of any Insured covered through it, the option to purchase all other individual coverage(s) being offered by Us for which the Policyholder qualifies.

In addition, if We choose to discontinue offering coverage in the individual market, We will provide 180-days prior written notice to the Washington State Insurance Commissioner and affected Insureds.

If this Policy is terminated or not renewed by the Policyholder or Us, coverage ends for You and Your Enrolled Dependents on the last day of the calendar month in which this Policy is terminated or not renewed so long as premium has been received for the calendar month.

MILITARY SERVICE

An Insured whose coverage under this Policy terminates due to entrance into military service may request, in writing, a refund of any prepaid premium on a pro rata basis for any time in which this coverage overlaps such military service.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the last day of the calendar month in which Your eligibility ends so long as premium has been received for the calendar month, or on the date assigned by the HBE.

Nonpayment of Premium

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

Termination by You
You have the right to terminate this Policy with respect to Yourself and Your Enrolled Dependents by giving notice to Us within 30 days or by contacting the HBE, which will provide Us with the notice of termination. Upon receiving a request for termination, We will cancel this Policy on the last day of the calendar month following the date We receive such notice so long as premium has been received for the calendar month. We will refund You any premium received on an Insured's behalf for any period of ineligibility, providing that no benefits were paid during the interim. However, it may be possible for an ineligible dependent to continue coverage with this Policy according to the provisions below.

GRACE PERIOD
A grace period of 30 days, or of 90 days for Insureds enrolling through the HBE whose premium is subsidized by the federal government's payment of a portion of Your premium as an advance of the premium tax credit, will be granted for the payment of the regular monthly premium after payment of the first month's premium. During this grace period this Policy shall not be terminated, however, if the premium has not been received by the last day of the grace period, this Policy shall be terminated at the end of the month for which premium has been paid in full.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Enrolled Dependents on the last day of the calendar month in which their eligibility ends so long as premium has been received for the calendar month, or on the date assigned by the HBE. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

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 calendar month following the date a divorce or annulment is final so long as premium has been received for the calendar month, or on the date assigned by the HBE.

Death of the Policyholder
If You die, coverage for Your Enrolled Dependents ends on the last day of the calendar month in which Your death occurs so long as premium has been received for the calendar month, or on the date assigned by the HBE.

Policy Continuation
In the event that an Insured shall no longer meet eligibility as set forth above due to divorce, annulment, or death of the Policyholder, such Insured shall have the right to continue the coverage of this Policy.

Termination of Domestic Partnership
If Your domestic partnership terminates, 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 calendar month following the date of termination of the domestic partnership so long as premium has been received for the calendar month, or on the date assigned by the HBE. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. This termination provision does not apply to any termination of domestic partnership that occurs as a matter of law because the 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
- Eligibility ends on the last day of the calendar month in which an enrolled child exceeds the dependent age limit so long as premium has been received for the calendar month, or the date assigned by the HBE.
- Eligibility ends on the date in which an enrolled child is removed from placement, or by the date assigned by the HBE, due to disruption of placement before legal adoption.

OTHER CAUSES OF TERMINATION
Insureds may be terminated for any of the following reasons as explained below.

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 this Policy will terminate for that Insured.

Fraud or Misrepresentation in Application

We have issued this Policy 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 an Insured, We will take any action allowed by law or Policy, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

General Provisions and Legal Notices

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

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

GOVERNING LAW AND BENEFIT ADMINISTRATION
This Policy 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 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 Insured rights under this benefit plan that include the right to Appeal, review by an Independent Review Organization and civil action.

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 in this Policy by reason of epidemic, disaster or other cause or condition beyond Our control.

MODIFICATION OF POLICY
We shall have the right to modify or amend this Policy from time to time. However, no modification or amendment will be effective until a minimum of 30 days (or as required by law) after written notice has been given to the Policyholder. The modification must be uniform within the product line and at the time of renewal.

However, when a change in this Policy is beyond Our control (for example, legislative or regulatory changes take place), We may modify or amend this Policy on a date other than the renewal date, including changing the premium rates, as of the date of the change in this Policy. We will give You prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify You in writing of a change of premium rates within 30 days after the later of the Effective Date or the date of Our implementation of a statute or regulation.

Provided We give notice of a change in premium rates within the above period, the change in premium rates shall be effective from the date for which the change in this Policy is implemented, which may be retroactive.

Payment of new premium rates after receiving notice of a premium change constitutes the Policyholder's acceptance of a premium rate change.

Changes can be made only through a modified Policy, amendment, endorsement or rider authorized and signed by one of Our officers. No other agent or employee of Ours is authorized to change this Policy.

NO WAIVER
The failure or refusal of either party to demand strict performance of this Policy 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 this Policy will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

NONASSIGNMENT
Only You are entitled to benefits with this Policy. 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.

NOTICES

Any notice to Insureds required in this Policy will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Insured will be addressed to the Insured and/or the Policyholder at the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for a Policyholder, We will update Our records accordingly. Additionally, We may forward notice for an Insured if We become aware that We don't have a valid mailing address for the Insured. Any notice to Us required in this Policy may be mailed to Our Customer Service address. However, 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 Policyholder on or before the premium due date, or within the grace period. Failure by the Policyholder to make timely payment of premiums may result in Our terminating this Policy on the last day of the calendar month through which premiums are paid or such later date as provided by applicable law.

If enrolling through the HBE, and the federal government is paying a portion of Your payment as an advance of the premium tax credit, the federal government will also determine if they will pay a portion of the payment for a new dependent.

Premium Charges

This Policy is issued in consideration of an accepted application or notification of enrollment through the HBE and the payment of the required premium charges. Premium charges are not accepted from third-party payers including employers, Providers, non-profit or government agencies, except as required by law.

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

Health information requested or disclosed by 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 visiting Our Web site or contacting Customer Service.

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

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

TAX TREATMENT

We do not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered, 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 in this Policy;
- the person has applied and has been accepted for coverage by Us or by the HBE; and
- premium for the person for the current month has been paid by the Policyholder 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, other terms are defined where they are first used.

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 only the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Oregon in the state of Oregon, Regence BlueShield in the state of Washington, and Regence BlueCross BlueShield of Utah in the state of Utah.

Allowed Amount means:

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

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

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

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

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

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

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

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

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 Insured's home.

Effective Date means the first day of coverage for You and/or Your dependents, following Our receipt and acceptance of the application by Us or by the HBE.

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

- placing the Insured's health, or with respect to a pregnant Insured, the Insured's health or the health

of the unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Enrolled Dependent means a Policyholder's eligible dependent who is listed on the Policyholder's completed application and who has been accepted for coverage under this Policy.

Experimental/Investigational means a Health Intervention that We have classified as Experimental or 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 Experimental or Investigational. A Health Intervention not meeting all of the following criteria, is, in Our judgment, Experimental or Investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-Reviewed Medical Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:

    - Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
    - Standard Reference Compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Upon receipt of a fully documented claim or request for preauthorization related to a possible Experimental or Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Contact Us 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.

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

Family means a Policyholder and any Enrolled Dependents.

Gender Affirming Treatment means Medically Necessary Covered Services provided by a Provider and prescribed in accordance with generally accepted standards of care, to treat any condition related to an individual's gender expression or identity.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or

palliate the following:

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

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

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

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

Illness means a:

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

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

Injury means physical damage to the body caused by:

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

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

In-Network means a contracted Provider with Us in Your Provider network who provides services and supplies to Insureds in accordance with the provisions of this coverage. Your Provider network is identified on the Schedule of Benefits and may include Our Affiliates. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, In-Network Providers include only Our identified Centers of Excellence for the particular therapy.

For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Insured means any person who satisfies the eligibility qualifications and is enrolled for coverage with this Policy.

Lifetime means the entire length of time an Insured is continuously covered by this Policy 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 to prevent, evaluate, diagnose or treat an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community,

Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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

Out-of-Network means a Provider that is not In-Network. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Out-of-Network Providers include any Provider that is not one of Our identified Centers of Excellence for the particular therapy.

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

Policy is the description of the benefits for this coverage. This Policy is also the agreement between You and Us for a health benefit plan.

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

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

Provider means:

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

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

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

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized

federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Service Area means the geographic area in Washington state where We have been authorized by the State of Washington to sell and market this plan and the area in which an individual must live in order to be eligible for this plan. Your Service Area is identified on the Schedule of Benefits.

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.

Washington Health Benefit Exchange (or HBE) means the state authorized entity which determines eligibility to enroll in plans offered by the HBE.

Appendix: Value-Added Services

Your Asuris coverage includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. These value-added services are voluntary, not insurance and are offered in addition to the benefits in this Policy.

For additional information regarding any of these value-added services, visit Our Web site or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

ASURIS MOTIVATE

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

- earning up to a total of $100 in gift cards for completion of well-being activities such as an online health risk assessment, health screening(s) and wellness examination(s);
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

INDIVIDUAL ASSISTANCE PROGRAM (IAP)

An IAP is short-term, confidential counseling at no out-of-pocket expense. This IAP is available to the following "clients":

- the Policyholder;
- the Policyholder's legal dependents (whether or not they are enrolled in this coverage or living in the Policyholder's home); and
- anyone living in the Policyholder's home (whether or not they are enrolled in this coverage or related to the Policyholder).

The following services are provided as part of this IAP:

- **24-Hour Crisis Counseling**
  The IAP hotline number is answered by professional counselors 24 hours a day, 7 days a week. Clients can call the hotline directly at 1 (866) 750-1327.

- **Short-Term Counseling**
  An "incident" means a separate event or events occurring in the client's life. Four counseling sessions will be covered per incident. Each client affected by an incident will be eligible for a total of four counseling sessions. If two or more clients are seen together in a joint session, the session is counted as one visit for each attending client.

- **Referral**
  If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor may refer the client to extended care, community resources or another Provider as best suited to address the issue and referred services will not be part of this IAP. Services not included in this IAP will be subject to the benefits in this Policy.

- **Follow-up**
  When necessary and appropriate, the counselor may follow up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if this IAP service can be of further assistance.

KIDNEY HEALTH MANAGEMENT

If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD). The program defers progression of CKD, reduces the cost of care by avoiding adverse events such as emergency room visits, hospitalizations and post-acute care.

PREGNANCY PROGRAM

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

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1 (888) JOY-BABY (569-2229) or visit Our Web site right away to get started.

For more information call Us at 1 (888) 232-8229

asuris.com