2021 BOOKLET FOR:

CITY OF LEWISTON EMPLOYEE BENEFIT PLAN TRUST
PLAN SPONSOR: CITY OF LEWISTON

Group Number: 10006006

Medical Benefits

This is a self-funded Plan and is not insurance and does not participate in the Idaho Life and Guaranty Association.

Regence

Regence BlueShield of Idaho is an Independent Licensee of the BlueCross and BlueShield Association

Introduction

This Booklet provides the written description of the terms and benefits of coverage available under the Plan. Your Plan is managed by the City of Lewiston Employee Benefit Plan Trust (hereafter referred to as the “Trust”). The administrative services contract between the Trust and Regence BlueShield of Idaho, Inc. (called the "Agreement") contains all the terms of coverage. Your employer has a copy.

This Booklet describes benefits effective **January 1, 2021**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueShield of Idaho and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the term "Claims Administrator“ refers to Regence BlueShield of Idaho, Inc. (hereafter referred to as "Regence BlueShield of Idaho") and the term "Plan Sponsor" refers to Your employer. References to "You" and "Your" refer to the Participant and/or Beneficiaries. The Trust may also be referred to as "Plan Administrator." Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

EMPLOYER PAID BENEFITS

This self-funded group health plan (hereafter referred to as "Plan") is an employer-paid benefits plan administered by the Claims Administrator. The Plan Sponsor contributes to the Trust to pay for Your covered medical services and supplies. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. This means that the Trust, on behalf of the Plan Sponsor, not Regence BlueShield of Idaho, pays for Your covered medical services and supplies. Your claims will be paid only after the Trust provides the Claims Administrator with the funds to pay Your benefits and pay all other charges due under the Plan.

This employee benefit plan may be governed by the Employee Retirement Income Security Act (ERISA). Throughout the Booklet, references to "ERISA" will apply only if the Plan is part of an employee welfare benefit plan regulated under ERISA.

Notice of Privacy Practices: Regence BlueShield of Idaho 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 (866) 240-9580
(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;
- if You would like to request written or electronic information regarding any other plan that the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's Web site, **regence.com**, to chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via the Claims Administrator's Web site); or
- for assistance in a language other than English.

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

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

Using Your Booklet

ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for care or treatment of an Illness or Injury. You control Your out-of-pocket expenses by choosing between "Category 1," "Category 2" and "Category 3" benefit levels.

- **Category 1.** Choosing preferred Providers saves You the most in Your out-of-pocket expenses. Preferred Providers will not bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.
- **Category 2.** Choosing participating Providers means Your out-of-pocket expenses will be higher than choosing a preferred Provider. Participating Providers will not bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.
- **Category 3.** Choosing nonparticipating Providers means Your out-of-pocket expenses will be higher than choosing a preferred or participating Provider. Also, a nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing. This is referred to as balance billing.

For each benefit, the Provider You may choose and Your payment amount for each provider option is indicated. See the Definitions Section for a complete description of Categories 1, 2 and 3. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **regence.com** to help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE PLAN.**

- **Go to regence.com.** You can use the Claims Administrator's secure Web site to:
  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - discover discounts on select items and services*;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE PLAN.**

ENHANCED SERVICES, SUPPORT, AND ACCESS

Your Plan Sponsor has chosen to include enhanced services, support, and access. These enhancements allow You to take better control over Your and Your family's health. Such services may include, but are not limited to:

- **Enhanced convenience and options for access to medical care.** These may include additional resources for You to receive covered medical care, such as enhanced virtual care options that are integrated with Your telehealth and telemedicine, Durable Medical Equipment, preventive, behavioral health, and/or other benefits. You may also be offered increased ease in accessing non-Covered Services, such as cosmetic services or in integrating care for complex and multi-Provider conditions.
- **Healthcare and vitality assistance tools.** You may have tools that enable You to make and track medical appointments; manage health care expenses; receive support in caring for others; remember

to timely refill prescriptions and perform regular self-care; track weight, food, and exercise statistics; and more.

- **Non-medical lifestyle enhancements.** These may include access or assistance with non-medical services, such as resilience, mindfulness, yoga or stress reduction programs, and pet wellness and insurances services.

Your Plan Sponsor's enhancements can be accessed through a single sign-on by visiting the Claims Administrator's Web site, or by contacting Customer Service. These services are specialized and may change over time. Your use of these additional services selected by Your Plan Sponsor is voluntary. In some cases, the Claims Administrator may have an affiliation with the entity that performs the services purchased by Your Plan Sponsor. The use of these services may result in savings or value to You, Your Plan Sponsor, and the Claims Administrator. **ANY SUCH ENHANCED SERVICES, SUPPORT, AND ACCESS ARE COMPLEMENTS TO THE PLAN.**

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Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Cost-Sharing and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Medical Benefits and Prescription Medications Sections 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 Medical Benefits Section 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 Plan, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before the Plan will provide payments for Covered Services. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. There are two Deductible amounts: one for Category 1 and 2 benefits combined and another for Category 3 benefits.

There are also two Family Deductible amounts: one for Category 1 and 2 benefits combined and another for Category 3 benefits. The Family Deductible is satisfied when the Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. However, no one Claimant will be required to meet more than the individual Deductible amount toward the Family Deductible in a Calendar Year.

The Plan does not pay for services applied toward the Deductible. Refer to the benefit sections to see what Covered Services are subject to the Deductible. A Claimant's Deductible amount paid toward Covered Services for ambulance, blood bank and emergency room services will apply toward the Category 1 and 2 Deductible amount. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible.

COPAYMENTS

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

COST-SHARING (PERCENTAGE YOU PAY)

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the maximum amount You could pay in a Calendar Year for Covered Services. The Out-of-Pocket Maximum is satisfied by Your payments of Deductible, Copayments and Cost-Sharing, unless specified otherwise. There are two Out-of-Pocket Maximum amounts: one for Category 1 and 2 benefits combined and another for Category 3 benefits.

There are also two Family Out-of-Pocket Maximum amounts: one for Category 1 and 2 benefits combined and another for Category 3 benefits. The Family Out-of-Pocket Maximum is satisfied when the Family members' Deductibles, Copayments and Cost-Sharing for Covered Services for that Calendar Year total and meet the Family Out-of-Pocket Maximum amount. However, no one Claimant will be

required to meet more than the individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year.

A Claimant's payment of any Deductible, Copayment and/or Cost-Sharing for ambulance, blood bank, emergency room services and Prescription Medications will apply toward the Category 1 and 2 Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services, Category 2 or Category 3 for Gene Therapy and Adoptive Cellular Therapy or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your Copayment and/or Cost-Sharing for Prescription Medications resulting from the use of a drug manufacturer coupon may not apply toward the Out-of-Pocket Maximum. If You do not fill Your Prescription Medication through a Specialty Pharmacy, You are required to notify the Claims Administrator of Your use of a drug manufacturer coupon. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

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

HOW CALENDAR YEAR BENEFITS RENEW

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

The Agreement is renewed each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. If the Agreement renews on a day other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the Agreement's renewal date will carry over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amounts increase during the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Agreement during the same Calendar Year.

Medical Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. Referrals are not required before You can use any of the benefits of this coverage, including women's health care services. All benefits are listed alphabetically, with the exception of Preventive Care and Immunizations, Office 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. All covered benefits are subject to the limitations, exclusions and provisions of this Plan. In some cases, the Plan 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 when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices purchased through an approved Commercial Seller are covered at the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, visit the Claims Administrator's Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's Web site, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. **ANY SUCH DISCOUNTS OR COUPONS ARE A COMPLEMENT TO THE PLAN.**

PREAUTHORIZATION

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

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

A complete list of services and supplies that require preauthorization may be obtained by visiting the Claims Administrator's Web site at: **regence.com/web/regence_provider/pre-authorization** or by calling Customer Service.

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

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

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

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Booklet will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and

they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

CALENDAR YEAR DEDUCTIBLES

Categories 1 and 2

Per Claimant: $1,500
Per Family: $3,000

Category 3

Per Claimant: $3,000
Per Family: $6,000

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Categories 1 and 2

Per Claimant: $3,000
Per Family: $6,000

Category 3

Per Claimant: $5,000
Per Family: $10,000

Be aware that Your actual costs for Covered Services provided by a nonparticipating Provider may exceed this Plan's Out-of-Pocket Maximum amount. Also, nonparticipating Providers can bill You for the difference between the amount charged and the Plan's Allowed Amount and that amount does not apply toward any Out-of-Pocket Maximum.

PREVENTIVE CARE AND IMMUNIZATIONS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.

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-women's care, well-baby care and routine health screenings;
- Provider counseling and Prescription Medications prescribed for tobacco use cessation;
- immunizations for adults and children;
- breast pump (including its accompanying supplies) per pregnancy as follows:
    - one new non-Hospital grade breast pump at the Category 1 benefit level when obtained from a Provider (including a Durable Medical Equipment supplier); or
    - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value.
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women, including, but not limited to:
    - female condoms;
    - diaphragm with spermicide;

- sponge with spermicide;
- cervical cap with spermicide;
- spermicide;
- oral contraceptives (combined pill, mini pill and extended/continuous use pill);
- contraceptive patch;
- vaginal ring;
- contraceptive shot/injection;
- emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
- intrauterine devices (both copper and those with progestin);
- implantable contraceptive rod;
- surgical implants; and
- surgical sterilization.

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

NOTE: Certain preventive care and immunization services that do not meet these criteria may be covered in this Preventive Care and Immunizations benefit when received and billed as preventive. 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, the Plan has up to one year before coverage of the related services must be available and effective. For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit the Claims Administrator's Web site or contact Customer Service.

Expanded Immunizations

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Coverage does not 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 VISITS – ILLNESS OR INJURY

	Category: 1	Category: 2	Category: 3
	Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Primary Physician or Practitioners	**Payment:** You pay $30 Copayment per visit	**Payment:** You pay $30 Copayment per visit	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Specialists (Includes Urgent Care)	**Payment:** You pay $50 Copayment per visit	**Payment:** You pay $50 Copayment per visit	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Office (including home and Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care 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, except as otherwise covered in the Expanded Office Services benefit.

Expanded Office Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Expanded office services are general medical services, surgical procedures, including anesthesia and supplies, and therapeutic injections (including clotting factor products) provided by a professional Provider. Expanded office services are covered when received in a Provider's office, urgent care or Retail Clinic and when billed as such.

Coverage does not include other professional services performed in the office that are specifically covered elsewhere in the Medical Benefits Section, such as, but not limited to, outpatient radiology and laboratory services, rehabilitation services or immunizations.

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

OTHER PROFESSIONAL SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible*, You pay 20% of the Allowed Amount. *Outpatient radiology and laboratory services are not subject to the Deductible.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Unless otherwise covered in the Expanded Office Services benefit, 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 for Claimants up to age 26, 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) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's Web site or contact Customer Service.

Professional Inpatient
Professional inpatient visits for treatment of Illness or Injury. If pre-arranged procedures are performed by a preferred Provider and You are admitted to a preferred Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by participating and nonparticipating Providers at the Category 1 benefit level. However, a nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing. Contact the Claims Administrator's Customer Service for further information and guidance.

Radiology and Laboratory
Diagnostic services for treatment of Illness or Injury. This includes Medically Necessary genetic testing and diagnostic mammography services not covered in the Preventive Care and Immunizations benefit.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the referring Provider is located, regardless of where the examination of the specimen occurred. Refer to Your Blue plan network where the referring Provider is located for coverage of independent clinical laboratory services.

Diagnostic Procedures
Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress tests, sleep studies and neurology/neuromuscular procedures.

Surgical Services
Surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist. Covered Services include vasectomies.

AMBULANCE SERVICES

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

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger Your health and the transportation is not for personal or convenience purposes. Covered 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's and Your identification numbers.

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

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

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

- approved or funded by one or more of:
    - the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those

entities; or a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
- a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
- the VA, DOD or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review.

- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

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

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

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

BLOOD BANK

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

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

COLONOSCOPY SERVICES

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Services and supplies for colonoscopies are covered when the colonoscopy is not performed as a preventive measure. Preventive colonoscopies may be covered in the Preventive Care and Immunizations benefit.

COMPLEMENTARY CARE

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 20% of the Allowed Amount.	**Payment:** You pay 20% of the Allowed Amount and the balance of billed charges. Your payment does not apply toward the Out-of-Pocket Maximum.
Limit: 15 visits for all complementary care combined per Claimant per Calendar Year		

The Plan covers the services and supplies of the following Providers: acupuncturists, massage therapists, chiropractors and naturopaths. The Plan also covers acupuncture and chiropractic care under this benefit when performed by any Provider.

DENTAL HOSPITALIZATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

DETOXIFICATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount and the balance of billed charges.

DIABETIC EDUCATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Services and supplies for diabetic self-management training and education are covered. Diabetic nutritional counseling and nutritional therapy are covered in the Nutritional Counseling benefit.

DIALYSIS

Inpatient

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Outpatient Initial Treatment Period

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: three months per Claimant (42 treatments of hemodialysis or 30 days peritoneal dialysis) for the initial treatment period		

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

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

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

Outpatient Supplemental Treatment Period (Following Initial Treatment Period)

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede Your benefits (or this benefit), You pay 0% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede Your benefits (or this benefit), You pay 0% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** The Plan pays 150% of the Medicare allowed amount at the time of service. If You are not enrolled in Medicare Part B, You pay the balance of billed charges.

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

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

"Medicare allowed amount" is the amount that a Medicare-contracted Provider agrees to accept as full payment for a Covered Service. This is also referred to as the Provider accepting Medicare assignment.

Case Managed Dialysis and Supplemental Kidney Dialysis Program

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

To learn more or to enroll in Case Management, call the Claims Administrator's Customer Service.

DURABLE MEDICAL EQUIPMENT

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes.

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's Web site or contact Customer Service.

Claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the locale in which the equipment was received. Durable Medical Equipment is received where it is purchased at retail or, if shipped, where the Durable Medical Equipment is shipped to. Refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $150 Copayment per visit and after Deductible, You pay 20% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** You pay $150 Copayment per visit and after Deductible, You pay 20% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** You pay $150 Copayment per visit and after Deductible, You pay 20% of the Allowed Amount and the balance of billed charges. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations 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 preauthorized.

"Stabilization" means to provide Medically Necessary treatment:

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

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Category: 1	Category: 2	Category: 3
Provider: Centers of Excellence	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 90% of the Allowed Amount. Your payment does not apply toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, You pay 90% of the Allowed Amount and the balance of billed charges. Your payment does not apply toward the Out-of-Pocket Maximum.

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Claimants who fulfill the Medical Necessity criteria.

To be covered at the Category 1 benefit level, gene therapy and/or adoptive cellular therapy must be received from one of the Claims Administrator's Centers of Excellence (COE) facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from a preferred Provider to be covered at the Category 1 benefit level. Receiving therapy from one of the Claims Administrator's COE facilities will save the most in Your out-of-pocket expenses. For a list of covered therapies or to identify a COE facility, contact the Claims Administrator's Customer Service, as the lists are subject to change.

Travel Expenses

Payment: After Deductible, You pay 100% of billed charges. Your payment may be reimbursed up to the travel expense limit.
Limit: $7,500 per Claimant per course of treatment, including companion(s), for transportation, lodging and meal expenses. Additional limitations included below.

Transportation, lodging and meal 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 a preferred Provider;
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to $300 per night for the Claimant and companion(s) combined;
- meal expenses are limited to $80 per day for each Claimant or companion(s); and
- covered transportation expenses to and from the treatment area include only:
    - commercial airfare;
    - commercial train fare; or
    - documented auto mileage (calculated per IRS medical allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. The Plan will reimburse You for Covered Services

associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

Coverage does not include incidentals outside of transportation, lodging and meals.

HEARING AIDS AND EVALUATIONS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: $5,000 per Claimant Lifetime		

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

- hearing aids (including evaluations);
- bone conduction sound processors (including examinations and fittings);
- ear molds and replacement ear molds; and
- hearing aid checks and testing.

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

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

Covered Services do **not** include:

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

HOME HEALTH CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: 130 visits per Claimant per Calendar Year		

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

Home health care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: 14 inpatient or outpatient respite care days per Claimant Lifetime		

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

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

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Services and supplies of a Hospital or an Ambulatory Surgical Center (including 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.

MATERNITY CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible*, You pay 20% of the Allowed Amount. *Deductible does not apply to Physician services.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), involuntary complications of pregnancy and related conditions are covered for all female Claimants. There is no limit for the mother's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the mother. Coverage also includes termination of pregnancy only when done to preserve the life of the female Claimant.

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.

The following involuntary complications of pregnancy are covered for all female Claimants, including a female Enrolled Child:

- ectopic pregnancy which is terminated;
- spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible;
- puerperal infection;
- eclampsia;
- toxemia; and
- conditions requiring inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical or surgical conditions of comparable severity.

Additionally, a cesarean section delivery resulting from involuntary complications of pregnancy is covered for all female Claimants, including a female Enrolled Child.

Involuntary complications of pregnancy do **not** include:

- false labor;
- occasional spotting;
- Physician-prescribed bed rest during the period of pregnancy;
- morning sickness;
- hyperemesis gravidarum;
- preeclampsia; and
- similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Definitions

The following definitions apply to this Maternity Care benefit:

Enrolled Spouse means a Beneficiary who is the spouse of the Participant.

Enrolled Child means a Beneficiary who is a child of the Participant or the Participant's spouse.

MEDICAL FOODS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Medical foods for inborn errors of metabolism are covered, including, but not limited to, formulas for Phenylketonuria (PKU). "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 OR SUBSTANCE USE DISORDER SERVICES

Inpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Outpatient Office/Psychotherapy Visits

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $30 Copayment per visit.	**Payment:** You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Other Outpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders.

Definitions

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

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

Mental Health Conditions mean mental 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 would otherwise be a Covered Service.

Substance Use Disorders mean substance-related disorders included in the most recent edition of the DSM. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products or foods.

NEURODEVELOPMENTAL THERAPY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Inpatient limit: unlimited **Outpatient limit:** 28 visits per Claimant per Calendar Year		

Inpatient and outpatient neurodevelopmental therapy services are covered. Covered Services must be to restore or improve function for a Claimant age six and under with a neurodevelopmental delay. "Neurodevelopmental delay" means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy, speech therapy and maintenance services, if significant deterioration of the Claimant's condition would result without the service.

Outpatient neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

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

NUTRITIONAL COUNSELING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: three visits per Claimant Lifetime (diabetic counseling is not subject to this limit)		

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. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOTIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Braces, splints, orthopedic appliances and orthotic supplies or apparatuses are covered when used to support, align or correct deformities or to improve the function of moving parts of the body.

Additionally, certain orthotic devices that are new are covered when obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's Web site or contact Customer Service.

The Plan may elect to provide benefits for a less costly alternative item. Off-the-shelf shoe inserts and orthopedic shoes are not covered.

PROSTHETIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, 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.

REHABILITATION SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Inpatient limit: 22 days per Claimant per Calendar Year **Outpatient limit:** 30 visits per Claimant per Calendar Year		

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated services such as massage when provided as a therapeutic intervention.

Rehabilitation days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

RETAIL CLINIC OFFICE VISITS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $30 Copayment per visit.	**Payment:** You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

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

SKILLED NURSING FACILITY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: 60 inpatient days per Claimant per Calendar Year		

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

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Inpatient and outpatient services are covered for treatment of TMJ disorders which have one or more of the following characteristics:

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

Covered Services include services that are:

- reasonable and appropriate for the treatment of a TMJ disorder;
- effective for the control or elimination of one or more of the following TMJ disorders:
    - pain;
    - infection;
    - disease;
    - difficulty in speaking; or
    - difficulty in chewing or swallowing food.

TOBACCO USE CESSATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Tobacco use cessation expenses not covered under the Preventive Care and Immunizations benefit are covered under this Tobacco Use Cessation benefit, as explained. A tobacco use cessation service means a service that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products. The Plan does not cover tobacco use cessation services provided by the following Providers: acupuncturists, massage therapists, chiropractors and naturopaths. See the Preventive Care and Immunization benefit and the Prescription Medications Section to see how tobacco use cessation Prescription Medications are covered.

TRANSPLANTS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Transplants are covered, including transplant-related services and supplies. 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 the Claims Administrator's 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.

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. Virtual care refers to the utilization of telehealth, telemedicine 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. Virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

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

Store and Forward Services

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Store and forward services are covered. "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. Store and forward services do not include, for example, non-secure HIPAA compliant telephone, fax, short message service (SMS) texting or e-mail communication. Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

Provider: Virtual Care Vendor	Category: 1 Provider: Preferred	Category: 2 Provider: Participating	Category: 3 Provider: Nonparticipating
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Telehealth services are covered. "Telehealth" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when You are not in a healthcare facility.

Telemedicine

Category: 1 Provider: Preferred	Category: 2 Provider: Participating	Category: 3 Provider: Nonparticipating
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Telemedicine services are covered. "Telemedicine" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when You are at a healthcare facility.

Prescription Medications

This section explains Your benefits and cost-sharing responsibilities 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 MEDICATION CALENDAR YEAR DEDUCTIBLES

Per Claimant: $200

You do not need to meet the Prescription Medication Deductible when You fill a prescription for a Generic Medication.

This Prescription Medication Deductible is calculated separately from any other Deductible. However, this Prescription Medication Deductible will be applied toward the Out-of-Pocket Maximum as further specified in the Understanding Your Benefits Section. Any costs in excess of the Covered Prescription Medication Expense that are charged by a Nonparticipating Pharmacy do not apply toward the Prescription Medication Deductible. In addition, the difference between the price of a Brand-Name Medication and its generic equivalent do not apply toward the Prescription Medication Deductible.

COPAYMENTS AND/OR COST-SHARING

After You meet the Prescription Medication Deductible, You are responsible for paying the following Copayment and/or Cost-Sharing amounts at the time of purchase, if the Pharmacy submits the claim electronically. Your Copayment and/or Cost-Sharing will be applied toward the Category 1 and 2 Out-of-Pocket Maximum as further specified in the Understanding Your Benefits Section.

However, You are not responsible for any Deductible, Copayment and/or Cost-Sharing when You fill prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List found on the Claims Administrator's Web site or by calling Customer Service.

Prescription Medications from a Pharmacy

- You pay $10 for each Generic Medication (for each 90-day supply)
- You pay 25% for each Preferred Brand-Name Medication with a $25 minimum and a $100 maximum
- You pay 50% for each Brand-Name Medication with a $75 minimum and a $200 maximum
- You pay 50% for each Compound Medication with a $75 minimum and a $200 maximum

Prescription Medications from a Mail-Order Supplier (for Each 90-Day Supply)

- You pay $10 for each Generic Medication
- You pay 25% for each Preferred Brand-Name Medication with a $25 minimum and a $100 maximum
- You pay 50% for each Brand-Name Medication with a $75 minimum and a $200 maximum
- You pay 50% for each Compound Medication with a $75 minimum and a $200 maximum

Prescription Medications from a Participating Specialty Pharmacy (for Each 30-Day Supply)

- You pay 50% up to $300 maximum for each Specialty Medication

Prescription Medications from a Nonparticipating Specialty Pharmacy (for Each 30-Day Supply)

- You pay 50% up to $300 maximum for each Specialty Medication

Brand-Name Prescription Medication Instead of Generic

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. At the time of purchase,

You will be responsible for the applicable Copayment and/or Cost-Sharing for the Brand-Name Medication in addition to the difference in cost between the equivalent Generic Medication and the Brand-Name Medication. The difference in cost does not apply toward the Prescription Medication Deductible or any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication must be dispensed, You will still be responsible for the difference in cost.

COVERED PRESCRIPTION MEDICATIONS

Prescription Medication benefits are available for the following:

- Prescription Medications;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Claimant is educated to self-inject;
- diabetic supplies, when obtained with a Prescription Order, including:
    - lancets;
    - test strips;
    - glucagon emergency kits; and
    - insulin syringes (syringes and needles purchased at the same time as insulin do not require a separate Copayment).
- certain continuous glucose monitors and insulin pumps that are on the Drug List may be purchased from a Pharmacy, when obtained with a Prescription Order; related supplies and other continuous glucose monitors or other insulin pumps are covered in the Durable Medical Equipment benefit;
- Compound Medications;
- 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 Medication; and
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee.

Additionally, the following preventive medications obtained from a Participating Pharmacy are covered at no charge to You, including, but not limited to:

- immunizations for adults and children according to, and as recommended by the CDC and/or USPSTF;
- certain preventive medications according to, and as recommended by the USPSTF and when obtained with a Prescription Order:
    - aspirin;
    - fluoride;
    - iron; and
    - medications for tobacco use cessation.
- FDA-approved women's prescription and over-the-counter contraception methods according to, and as recommended by the HRSA and when obtained with a Prescription Order:
    - female condoms;
    - diaphragm with spermicide;
    - sponge with spermicide;
    - cervical cap with spermicide;
    - spermicide;
    - oral contraceptives (combined pill, mini pill and extended/continuous use pill);
    - contraceptive patch;
    - vaginal ring;
    - contraceptive shot/injection; and
    - emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products).

When preventive medications or immunizations are obtained from a Nonparticipating Pharmacy, You will be responsible for any Deductible, Copayment and/or Cost-Sharing listed above for Prescription Medications. If Your Provider believes that the Plan's covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit the Claims Administrator's Web site or contact Customer Service.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Preauthorization

Some Prescription Medications may require preauthorization before they are dispensed. The Claims Administrator notifies participating Providers, including 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 the Claims Administrator's Web site or contact Customer Service.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on the Claims Administrator's Web site or by contacting Customer Service.

You must present Your identification card to identify Yourself as a Claimant of this Plan when obtaining Prescription Medications from a Pharmacy or Mail-Order 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. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Plan will pay the Nonparticipating Pharmacy directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Cost-Sharing shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Claims Not Submitted Electronically

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

However, 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 the Claims Administrator. To find the Prescription Medication claim form, visit the Claims Administrator's Web site or contact Customer Service.

The Plan will reimburse You directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Cost-Sharing that would have been required had the medication been purchased from a Participating Pharmacy.

Mail-Order

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

You may also obtain covered Prescription Medications from a non-contracted mail-order Pharmacy, if the non-contracted mail-order Pharmacy is registered and agrees to dispense covered Prescription Medications according to the same terms and conditions as those provided by a Mail-Order Supplier. In this case, covered Prescription Medications dispensed by the non-contracted mail-order Pharmacy will be covered in the same manner as covered Prescription Medications dispensed by a Mail-Order Supplier.

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

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

Prescription Medications Dispensed by Excluded Pharmacies

The Claims Administrator does 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;
    - except, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.
- a Mail-Order Supplier are covered after You have taken all but 20 days of the previous Prescription Order.

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.

Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of a drug manufacturer coupon may not apply toward the Out-of-Pocket Maximum. If You do not fill Your Prescription Medication through a Specialty Pharmacy, You are required to notify the Claims Administrator of Your use of a drug manufacturer coupon.

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 purchased from a Specialty Pharmacy, is a 30-day supply. Specialty Medications are not allowed through Mail-Order Suppliers.
    - The first fill of Specialty Medications for hemophilia is allowed at a Pharmacy. Additional fills must be provided by a Specialty Pharmacy or Specialty Pharmacy designated as a Hemophilia Treatment Center (HTC).

- **34-Day or Greater Supply Limit:**

  - **Pharmacy** – the largest allowable quantity of a Generic Medication purchased from a Pharmacy is a 90-day supply. The Copayment and/or Cost-Sharing is based on each 90-day supply. The largest allowable quantity of a Preferred Brand-Name or Brand-Name Prescription Medication purchased from a Pharmacy is a 34-day supply. The Copayment and/or Cost-Sharing is based on each 34-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Mail-Order Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Injectable Medications** – The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy is a 34-day supply. The Copayment and/or Cost-Sharing for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
  - **Multiple-Month Supply** – the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is a 90-day supply (even if the packaging includes a larger supply). The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The Copayment and/or Cost-Sharing is based on each 34-day supply for Preferred Brand Name and Brand-Name Medications or each 90-day supply for Generic Medications within that multiple-month supply.

- **Maximum Quantity Limit:**

  - For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the 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 Claimant'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 Claims Administrator determines 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 the Claims Administrator's 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.

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.

Growth Hormones

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

Prescription Medications with Lower Cost Alternatives
Except for higher cost Prescription Medications that are Medically Necessary, Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives or over-the-counter (nonprescription) alternatives are not covered.

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. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe:

- an opioid antagonist to a Claimant who is at risk of experiencing an opiate-related overdose; or
- an epinephrine auto-injector to a Claimant who is at risk of experiencing anaphylaxis.

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

Travel Immunizations
Immunizations for travel, occupation or residency in a foreign country.

DEFINITIONS
The following definitions apply to this Prescription Medications Section:

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

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

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

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references as a Generic Medication. "Equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. Medications available only

from one source (also referred to as "single source") are not considered Generic Medications. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, the Claims Administrator will decide.

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

Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to.

Nonparticipating Specialty Pharmacy means a Specialty Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to.

Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access.

Participating Specialty Pharmacy means a Specialty Pharmacy with which the Claims Administrator has a contract or a Specialty Pharmacy that participates in a network for which the Claims Administrator has 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 his or her 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. The P&T Committee also provides input and oversight of the development of the Claims Administrator's 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 mean 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.

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 the Claims Administrator's 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. The Claims Administrator does not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Medications mean 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 the Claims Administrator's Web site or contact Customer Service.

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 the Claims Administrator's Web site or contact Customer Service.

Care Management and/or Wellness Programs

The Plan Sponsor has chosen to provide these additional services to You that are only available through the Claims Administrator, Regence BlueShield of Idaho. Should any of the additional services provide coverage to an also Covered Service under the Plan, the benefit under the Plan applies first until that benefit is exhausted.

CASE MANAGEMENT

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

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

REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include a health assessment, incentives to reward participation in healthy activities and online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals. To get started and access the resources available, visit **regence.com**.

General Exclusions

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

SPECIFIC EXCLUSIONS

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

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

Applied Behavior Analysis (ABA) Therapy

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.

Certain Therapy, Counseling and Training
Except as provided in the Employee Assistance Program (EAP) Section, if applicable, 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;
- EAP services; and
- job skills or sensitivity training.

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

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

Cosmetic/Reconstructive Services and Supplies
Except for treatment of the following, cosmetic and/or reconstructive services and supplies are not covered:

- a Congenital Anomaly for Claimants up to age 26;
- 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.

"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 performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

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

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

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

Elective Abortion
Except when performed to preserve the life of the enrolled female Claimant, termination of pregnancy (elective abortion) is not covered.

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

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

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

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

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

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

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

Growth Hormone Therapy

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

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 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;
- fertility medications;
- uterine transplants; 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.

Motor Vehicle Coverage and Other Available Insurance
When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Claimant (whether or not the Claimant makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Claims Administrator's Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

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

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

Obesity or Weight Reduction/Control
Except as provided in the Nutritional Counseling benefit 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:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea; or
- Congenital Anomaly.

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

Over-the-Counter Contraceptives
Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered.

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.

Riot, Rebellion and Illegal Acts
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's **voluntary participation in** any of the following:

- a riot;
- an armed invasion or aggression;
- an insurrection;
- a rebellion; or
- an act deemed illegal by an officer or a court of law.

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 a Claimant, self-help, non-medical self-care and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:

    - teach a person how to use Durable Medical Equipment;
    - teach a person how to care for a family member; or
    - provide a supportive environment focusing on the Claimant's long-term social needs when rendered by individuals who are not Providers.

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

"Immediate family" means:

- You and Your parents, parents' spouses or 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;
    - marriage;
    - insurance;
    - occupational injury benefits;
    - licensure; or
    - certification.

- immigration or emigration.

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

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

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

Travel Immunizations
Immunizations for travel, occupation or residency in a foreign country.

Varicose Vein Treatment
Except for the following, treatment of varicose veins is not covered:

- when there is associated venous ulceration; or
- persistent or recurrent bleeding from ruptured veins.

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

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

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

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

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

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, the Claims Administrator decides whether to pay You, the Provider or You and the Provider jointly. The Plan may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

Category 1 and Category 2 Claims and Reimbursement

You must present Your identification card to a preferred or participating Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to the Claims Administrator for processing Your claim.

The Plan will pay a preferred or participating Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Cost-Sharing at the time You receive care or treatment. Preferred and participating Providers have agreed not to bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing and to accept the Allowed Amount as payment in full for Covered Services.

Category 3 Claims and Reimbursement

In order for the Claims Administrator to pay for Covered Services, You or the nonparticipating Provider must first send the Claims Administrator a claim. In most cases, the Plan will pay You directly for Covered Services provided by a nonparticipating Provider. Be sure the claim is complete and includes the following information:

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

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

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

Timely Filing of Claims

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

Claim Determinations

Within 30 days of the Claims Administrator's receipt of a claim, the Claims Administrator will notify You of their action. However, this 30-day period may be extended by an additional 15 days due to lack of

information or extenuating circumstances. The Claims Administrator will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.

If the Claims Administrator requires additional information to process the claim, the Claims Administrator must allow You at least 45 days to provide it to them. If the Claims Administrator does not receive the requested information within the time allowed, the Claims Administrator will deny the claim.

OUT-OF-AREA SERVICES

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

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

BlueCard Program

In the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what the Claims Administrator agreed to in the Agreement. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

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

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

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

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

Value-Based Programs

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

The following definitions apply:

- Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

- Provider Incentive: An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination in a Value-Based Program.

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

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

Nonparticipating Providers Outside the Claims Administrator's Service Area

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

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard service area, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

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

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

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the

service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your Beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Trust has the right to recover the payment from the person the Plan paid or anyone else who benefited from it, including a Provider of services. The Trust's right to recovery includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any of his or her Beneficiaries, even if the mistaken payment was not made on that person's behalf.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). The Plan will be credited all amounts recovered.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the Subrogation and Right of Recovery provision for additional information.

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Illness, Injury or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

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

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

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

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

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

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

Cooperation
You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Illness, Injury or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any

settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

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

Workers' Compensation

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

Future Medical Expenses

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

Interpretation

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

Jurisdiction

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

COORDINATION OF BENEFITS

If You are covered by any other Plan (as defined below), the benefits in this Booklet and those of the other Plan will be coordinated in accordance with the provisions of this section.

Definitions

The following are definitions that apply to this Coordination of Benefits provision:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including Cost-Sharing or Copayments and without reduction for any applicable Deductible. In no event shall benefits payable under this Plan and another Plan exceed the allowable charges for such benefits. The following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved Plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless Your stay in a private Hospital room is Medically Necessary or one of Your involved Plans provides coverage for private Hospital rooms.
- Any expenses for other types of coverage or benefits when this coverage restricts coordination of benefits to certain types of coverage or benefits. This Coordination of Benefits provision applies to all benefits provided in this Booklet.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or failed to use a preferred Provider.

When a Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday means only the day and month in a Calendar Year and does not include the year in which the Claimant is born.

Closed Panel Plan means a Plan that provides health benefits to a Claimant primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan shall provide benefits as if it were the Primary Plan when a Claimant uses a non-panel provider, except for emergency services or authorized referrals that are provided by the Primary Plan.

Custodial Parent means the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation is the Custodial Parent.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to the covered person.

Plan means any of the following with which this coverage coordinates benefits:

- group and non-group insurance contracts and subscriber contracts;
- uninsured group or Group-Type Coverage arrangements;
- group and non-group coverage through Closed Panel Plans;
- Group-Type Coverage;
- medical care components of long-term care coverage, such as skilled nursing care;
- Medicare or other governmental benefits, except as provided below; and
- medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.

Plan does **not** include:

- hospital indemnity coverage or other fixed indemnity coverage;
- school accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis";
- specified disease or specified accident coverage;
- accident only coverage;
- long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or that pay a fixed daily benefit without regard to actual expenses incurred or services;
- limited benefit health coverage;
- Medicare supplement coverage;
- a Medicaid state plan; or
- a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the Plan that must determine its benefits for Your health care before the benefits of another Plan and without taking the existence of that other Plan into consideration. (This is also referred to as that Plan being "primary" to that other Plan.) There may be more than one Primary Plan. A Plan is a Primary Plan with regard to another Plan in any of the following circumstances:

- the Plan either has no order of benefit determination provision, or its rules differ from those permitted in this provision; or
- both Plans use the order of benefit determination provision included herein and by that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan. You may have more than one Secondary Plan. If You are covered by more than one Secondary Plan, the order of benefit determination provision decides the order in which Your Secondary Plans' benefits are determined in relation to each other.

Year means Calendar Year (January 1 through December 31).

Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that apply:

Non-dependent Coverage: A Plan that covers You other than as a dependent will be primary to a Plan for which You are covered as a dependent (except where this order of benefits would cause a violation of federal law concerning coordination of benefits with Medicare).

Dependent Coverage: Unless there is a court decree stating otherwise, Plans that cover You as a child shall determine the order of benefits as follows:

For a child whose parents are married or living together (whether or not they have ever been married):

- The Plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a Plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year.
- If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by his or her Plan longer shall be primary to the Plan of the parent who has been covered by his or her Plan for a shorter period.

For a child whose parents are divorced, separated or that are not living together (whether or not they have ever been married):

- If a court decree specifies that one of Your parents is responsible for Your health care expenses or health care coverage and that parent's Plan has actual knowledge of that term of the decree, the Plan of that parent is primary to the Plan of Your other parent. If the parent with responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. 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 Contract Year.
- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or a court decree states that the parents have joint custody without specifying that one parent has responsibility for Your health care expenses or health care coverage:
    - The Plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a Plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year.
    - If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by his or her Plan longer shall be primary to the Plan of the parent who has been covered by his or her Plan for a shorter period.
- If there is no court decree allocating responsibility for Your health care expenses or health care coverage:
    - The Plan covering the Custodial Parent shall be primary to the Plan covering Your Custodial Parent's spouse.
    - The Plan of Your Custodial Parent's spouse shall be primary to the Plan covering Your noncustodial parent.
    - Then the Plan covering Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

For a child covered by more than one Plan of individuals who are not the parents of the child, the order of benefit determination shall be determined as per the provisions set forth above as if those individuals were parents of the child.

Active/retired or laid-off employees: A Plan that covers You as an active employee (or as that employee's dependent) is primary to a Plan by which You are covered as a retired or laid off employee (or as the dependent of a retired or laid off employee). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

Continuation coverage: A Plan which covers You as an employee or retired employee, or as an employee's or retired employee's dependent, will be primary to a Plan that is providing continuation coverage (pursuant to COBRA or a right of continuation by state or other federal law). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply. This paragraph does not apply if an order of benefit determination can be made by the non-dependent coverage paragraph above.

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the Plan that has covered You for the longer period of time will be determined before the benefits of the Plan that has covered You for the shorter period of time. To determine the length of time You have been covered by a Plan, two Plans will be treated as one if You were eligible by the second within 24 hours after the first ended. The start of a new Plan does not include:

- a change in the amount or scope of a Plan's benefits;
- a change in the entity that pays, provides or administers the Plan's benefits; or
- a change from one type of Plan to another (such as from a single-employer Plan to a multiple employer Plan).

Your length of time covered by a Plan is measured from Your first date of coverage with that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage with the present Plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the Plans shall share equally in the Allowable Expenses.

Each of the Plans by which You are covered, and each of the benefits within the Plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, the Plan will pay the benefits in this coverage as if no other Plan exists.

Secondary Health Plan Benefits

If, in accordance with the order of benefit determination, one or more Plans are primary to this coverage, the benefits in this Plan will be calculated as follows:

The Claims Administrator will calculate the benefits that the Plan would have paid for a service if this coverage were the Primary Plan. The Claims Administrator will compare the Allowable Expense in this Plan for that service to the Allowable Expense for it with the other Plan(s) by which You are covered. This Plan will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) Allowable Expenses among the involved Plans, and
- the benefits that the Plan would have paid for the service if this coverage were the Primary Plan.

Deductibles, Cost-Sharing and Copayments in this coverage will be used in the calculation of the benefits that the Plan would have paid if this were the Primary Plan, but they will not be applied to the unpaid charges You owe after the Primary Plan's payment. The Plan's payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved Plans and the Plan will credit toward any Deductible in this coverage any amount that would have been credited to Deductible if this coverage had been the only Plan.

If this coverage is the Secondary Health Plan according to the order of benefit determination and any other Plan(s) claim to be "always secondary" or use order of benefit determination rules inconsistent with those in this Plan, this Plan will pay its benefits first, but the amount paid will be calculated as if this coverage is a Secondary Health Plan. If the other Plan(s) do not provide the Claims Administrator with the information necessary for the Claims Administrator to determine the Plan's appropriate secondary benefits payment within a reasonable time after their request, the Claims Administrator shall assume their benefits are identical to this Plan's and the Plan will pay benefits accordingly, subject to adjustment upon receipt of the information requested from the other Plan(s) within two years of this Plan's payment.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered by this coverage. Further, in no event will this Coordination of Benefits provision operate to increase the Plan's payment over what the Plan would have paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

Certain facts are needed to apply coordination of benefits provisions. The Claims Administrator has the right to decide which facts they need. The Claims Administrator may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits in this Booklet.

Facility of Payment

Any payment made by any other Plan(s) may include an amount that should have been paid by this coverage. If so, the Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this coverage. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the Plan provides benefits to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage with any other Plan(s), the Claims Administrator will be entitled to recover from You, Your assignee or beneficiary, or from the other Plan(s) upon request.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by the Claims Administrator under the Plan and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration may qualify for a level of expedited Appeal and are described separately later in this section.

FILING APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueShield of Idaho, P.O. Box 91015, Seattle, WA 98111-9115 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator's Customer Service.

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

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

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

Second-Level Appeals

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

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO)

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

The Claims Administrator coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will make their decision and provide You with written determination within 45 days of receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law.

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

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

First-Level Expedited Appeal

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

Voluntary Expedited External Appeal – IRO

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

The Claims Administrator coordinates voluntary expedited external Appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the Appeal documentation. The IRO will provide verbal notice of their decision to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of receipt of Your request. A written notification of their decision will be mailed to You 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 and this section, 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 under the Plan. This includes, but is not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If You have any questions about the Appeal Process contact the Claims Administrator's Customer Service or write to the following address: Regence BlueShield of Idaho, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS

The following definitions apply to this Appeal Process Section:

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

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

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary external expedited Appeals, through an

independent contractor relationship with the Claims Administrator and/or through assignment to the Claims Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Claims Administrator.

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

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

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

Eligibility and Enrollment

EMPLOYEES

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

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of initially becoming eligible for coverage per the eligibility requirements in effect with the Plan Sponsor and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

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

Employees

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

Dependents

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

- The person to whom You are legally married (spouse).
- Your (or Your spouse's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's) natural child, stepchild, adopted child or child legally Placed with You (or Your spouse) for adoption;
    - a child for whom You (or Your spouse) have court-appointed legal guardianship; or
    - a child for whom You (or Your spouse) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's) child who is age 26 or over and incapable of self-support because of intellectual disability or physical handicap that began before his or her 26th birthday. You must complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
    - he or she is a Beneficiary immediately before his or her 26th birthday; or
    - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

    The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site or calling Customer Service.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request and the appropriate payment (if any) is received by the Claims Administrator within 31 days of the date the monthly payment invoice is received by the Plan Sponsor and a notice of payment (if any) is provided to You by the Plan Sponsor.

Enrollment will be effective from:

- the moment of birth for a Newborn Child if a completed enrollment form is received within 60 days following the date of birth; or
- Placement of a Newly Adopted Child with the Participant for 60 days, but will continue from then on only if a completed enrollment form is received within 60 days following Placement with the Participant.

If the date of birth for the Newborn Child or date of Placement for the Newly Adopted Child is on or before the 15th of the month, the payment will be billed for the entire month. If date of birth or date of Placement is after the 15th, the payment will commence with the first day of the month following birth or Placement.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual enrollment period. You must submit an enrollment form on behalf of all individuals who become eligible based on the provisions below.

If You declined coverage when first eligible, You (unless already enrolled) and/or Your eligible dependents are eligible to enroll for coverage under the Plan within 30 days from the date of one of the following qualifying events:

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
    - an employer's contributions to that other plan are terminated;
    - exhaustion of federal COBRA or any state continuation; or
    - loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than Children's Health Insurance Program (CHIP)).
    - NOTE: If the qualifying event is involuntary loss of coverage with Medicaid or CHIP, You have 60 days from the date of the qualifying event to enroll.
- You lose coverage under Medicaid or CHIP.

For the above qualifying events coverage will be effective on the day after the prior coverage ended. Loss of eligibility does not include a loss because You failed to timely pay Your portion of the cost of coverage or when termination of coverage was due to fraud. It also doesn't include Your decision to terminate coverage. However, it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You declined coverage when first eligible, You (unless already enrolled) and/or Your eligible dependents are eligible to enroll for coverage under the Plan within 60 days from the date of one of the following qualifying events:

- You marry;
- You acquire a new child by birth, adoption or Placement for adoption; or
- You and/or Your eligible dependents become eligible for premium assistance with Medicaid or CHIP.

For the above qualifying events coverage will be effective on the first of the calendar month following the date of the qualifying event. However, if the qualifying event is a child's birth, adoption or Placement for adoption or You marry, coverage is effective from the date of the qualifying event.

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. The Claims Administrator must receive such information before enrolling a person as a dependent under the Plan.

RETIREES

If You meet the eligibility criteria described below at the time of Your retirement, You and Your eligible dependents will have access to City of Lewiston Retiree Medical coverage until You become eligible for Medicare. After You or Your covered dependents become Medicare eligible for any reason (for example, because of reaching age 65 or becoming disabled), Your and Your dependents' participation in this Plan will end.

This Booklet provides general information about the Plan's Retiree Medical coverage, such as who is eligible, how to enroll, who pays for the coverage and Plan administrative information. Specific information about covered services, cost-sharing, limitations and exclusions is also included.

This Booklet describes the terms of the Plan as in effect on January 1, 2021, and supersedes all prior Plan documents and communications.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You are eligible to participate in this Plan if You are a Participant who satisfies the following conditions at the time of Your retirement:

- You were hired before May 1, 2005 or You were rehired after May 1, 2005 with a break in service of less than 12 months,
- You and any dependents You wish to cover were participating in medical coverage through City of Lewiston while You were an active employee through Your retirement date,
- You retire from City of Lewiston at age 55 or later, and have at least 15 years of vesting service; or retire from City of Lewiston at age 50 or later and have at least 15 years of vesting service in Public Safety, and,
- You are not eligible for Medicare.

You are required to enroll in other employer sponsored healthcare program if eligible. If You retire from City of Lewiston and You are employed by another organization that offers employee benefits, You are required to enroll in that medical plan as a primary benefit program.

If You choose to enroll in the City of Lewiston Retiree medical plan, the retiree benefits offered by City of Lewiston will be the secondary coverage plan.

When You become eligible for Medicare (because You reach age 65 or become disabled), You are no longer eligible to participate in this Plan.

DEPENDENTS

If You are eligible to participate in this Plan, You may also enroll Your Beneficiaries in City of Lewiston retiree medical coverage if certain conditions are satisfied. The dependent eligibility rules under this Plan are slightly different than the dependent eligibility rules for active employees.

For purposes of this Plan, eligible dependents must satisfy two requirements. First, the dependent must have been covered under the City of Lewiston Medical Plan at the time of Your retirement. Second, the dependent must be one of the following:

- Your spouse.
- Your dependent prior to age 65 if the dependent is described in one of the following three eligibility groups.
    - Your unmarried children from birth to age 26. From age 19-26 the child must be a full-time student (with certain exceptions for certain medical leaves of absence as discussed under the heading **Michelle's Law**). From birth to age 26, the child must reside with You (except in certain divorce situations) and cannot provide over half of his or her own support. If Your child does not reside with You and **does not** live with a foster parent, stepparent, grandparent, sibling, aunt or uncle,

or if the child is age 25, the child may still be Your dependent if **You** provide over half of the child's support.

- Your unmarried children 26 and older who are physically or mentally disabled, if they reside with You, (except in certain divorce situations) and do not provide over half of their own support. If Your disabled child does not reside with You and does not live with a foster parent, stepparent, grandparent, sibling, aunt or uncle, the child may still be Your dependent if You provide over half of the child's support. The child must have been disabled and covered under the Plan (or another health plan) prior to age 19. Coverage may be continued as long as the child remains disabled and You remain enrolled in the Plan. Proof of disability may be required.
- Your children, including:
    - stepchildren;
    - legally adopted children;
    - children placed with You for adoption by You; and
    - any children for whom You are legally responsible to provide support and maintenance.

Children does not include children for whom You are a temporary guardian.

If You have questions regarding whether an individual qualifies as an eligible dependent, contact Human Resources.

When Your covered Beneficiaries become eligible for Medicare (because they reach age 65 or become disabled), they will no longer be eligible to participate in this Plan. If You become eligible for Medicare before Your covered Beneficiaries become eligible for Medicare, Your Beneficiaries may continue to participate in this Plan as long as they continue to satisfy the eligibility requirements of this Plan. If Your covered Beneficiaries become eligible for Medicare before You become eligible for Medicare, You may continue to participate in this Plan as long as You continue to satisfy the eligibility requirements of this Plan.

Michelle's Law

If Your dependent child is enrolled and covered under the Plan as a full time student from age 19 to 26 and he or she experiences a serious illness or injury that requires a medical leave of absence from school or a medically necessary change in enrollment status from full-time to part-time, the child may be eligible for up to a one-year extension of eligibility for retiree medical coverage, provided that the serious illness or injury causing the leave of absence or change in enrollment status is adequately documented by a physician and such documentation is provided to the medical plan in which You are enrolled. If eligible, Your dependent will continue to be covered as an eligible dependent for 12 months after the leave of absence or medically necessary change in enrollment status begins despite the fact that he or she is not a full-time student. However, the 12 months will not extend coverage beyond another independent event that would otherwise end dependent status, such as marriage or attainment of age 26.

Qualified Medical Child Support Orders (QMCSO)

In certain circumstances a court may order that You enroll a child under this Plan by filing a "QMCSO" with the City of Lewiston. A "QMCSO" may only be filed with respect to a retiree who enrolls in the Plan and may only cover a child who meets age and student status criteria described previously. For more information or for a copy of the Plan's QMCSO procedures, contact Human Resources. This information is available at no charge.

HOW TO ENROLL IN THE PRE-65 RETIREE COVERAGE

If You want retiree medical coverage through the City of Lewiston, You must enroll in retiree medical coverage within 31 days of the date Your City of Lewiston coverage as an active employee would otherwise end. As long as You enroll within 31 days, Your City of Lewiston retiree medical coverage will be effective as of the first of the month following the month in which You retire. If You want retiree medical through another retiree health plan (such as through a spouse's plan), or an individual insurance policy, You must enroll in that coverage as soon as possible.

RETIREE MEDICAL OPTIONS

If You retire on or after January 1, 2020 and meet the eligibility requirements, You can enroll in the company medical plan. Until You become eligible for Medicare, You and Your Beneficiaries will have access to retiree medical coverage options under this Plan. When You or Your Beneficiaries become eligible for Medicare (based on reaching age 65 or disability), You or Your Beneficiaries will no longer be eligible to participate in this Plan.

The retiree medical options are reviewed each year and any material changes will be communicated to You before their effective date.

There is no annual enrollment for this Plan.

Tiers of Coverage

When You enroll in City of Lewiston retiree medical and dental coverage, You will choose from the following types of coverage:

- Participant only;
- Participant plus spouse;
- Participant plus one child;
- Participant plus two or more children;
- Participant plus spouse and one child; or
- Participant plus spouse and two or more children.

Once You have made Your initial election, the only change You can make in Your coverage level is to lower Your level of coverage (for example, from couple to single). If You return to work at the City of Lewiston as an active employee, Your Retiree Plan coverage will be frozen until Your active employment ends.

Payment for Coverage

You pay the full cost of Your medical coverage as a retiree. There is no subsidy from the City of Lewiston. If You enroll in the City of Lewiston retiree medical coverage, You will receive cost-share payment instructions from the company when You retire. You must pay Your cost-share on a timely basis. Failure to pay cost-shares on a timely basis may result in cancellation of Your retiree medical coverage.

Death of a Participant

If You are enrolled in the City of Lewiston retirement benefits when You die, Your Beneficiaries will continue to have access to retiree medical coverage through the City of Lewiston. They must continue to pay all required Cost-Shares.

When Coverage Ends

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

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

AGREEMENT TERMINATION

If the Agreement is terminated or not renewed by the Plan Sponsor, claims administration by Regence BlueShield of Idaho ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed. Regence BlueShield of Idaho may administer certain claims for Covered Services that Claimants received before the Agreement termination or nonrenewal, if agreed between the Plan Sponsor and the Claims Administrator.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

Termination of Your Employment or You are No Longer Eligible

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

Nonpayment

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

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions.

Divorce or Annulment

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

Death of the Participant

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

Loss of Dependent Status

- Eligibility ends on the last day of the monthly period in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the date in which an enrolled child is removed from Placement due to disruption of Placement before legal adoption.
- Eligibility ends on the last day of the monthly period in which an enrolled child is no longer an eligible dependent for any other cause not described above.

OTHER CAUSES OF TERMINATION

Claimants terminated for the following reason may be able to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions.

Fraud or Misrepresentation

The Plan is issued in reliance upon all information furnished to the Claims Administrator by You or on behalf of You and Your Beneficiaries. No statement made for effecting coverage will void such coverage or reduce benefits unless such statement is contained in a written instrument signed by You.

In the event of any intentional misrepresentation of material fact or fraud by the Plan Sponsor, coverage under the Plan will terminate.

FAMILY AND MEDICAL LEAVE

If Your Plan Sponsor grants You a leave of absence per the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage with this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - to care for Your Newborn Child;
    - to care for Your spouse, child or parent with a serious health condition;
    - the Placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or Mental Health Condition.

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

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

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

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

LEAVE OF ABSENCE

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

A leave of absence is a Plan Sponsor-granted period off work made at Your request during which You are still considered to be employed and are carried on the Plan Sponsor's employment records. A leave can

be granted for any reason acceptable to the Plan Sponsor. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Plan only for a period equivalent to FMLA leave and may not also continue coverage with a non-FMLA leave.

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

CERTIFICATES OF CREDITABLE COVERAGE

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

COBRA Continuation of Coverage

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

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

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

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

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

General Rules

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

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

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

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

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

Notice

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

Other Continuation Options

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

Availability of Other Coverage

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

Pregnancy

If the Plan provided for maternity benefits and any female Claimant is pregnant at the time of termination of the Plan and the female Claimant is not eligible for any replacement group coverage within 60 days of the termination of the Plan, the Plan will provide benefits for pregnancy, childbirth or miscarriage as detailed in this Booklet for a period not to exceed 12 months beyond the date of termination.

General Provisions and Legal Notices

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

CHOICE OF FORUM

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

GOVERNING LAW AND DISCRETIONARY LANGUAGE

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

LIMITATIONS ON LIABILITY

You have the exclusive right to choose a health care Provider. The Plan and the Claims Administrator are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan and the Claims Administrator do not provide any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT – STATEMENT OF RIGHTS

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

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

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

NO WAIVER

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

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

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

A Plan holder entitled to vote on any matter of corporation business may not assign or in any way delegate such voting right to any other person or entity, other than by a validly executed written proxy filed with the Claims Administrator in compliance with the Claims Administrator's bylaws.

NOTICES

Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan Sponsor will be addressed to the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address (COA) form for a Participant, the Claims Administrator will update their records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor if they become aware that the Claims Administrator doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be mailed to: Regence BlueShield of Idaho, P.O. Box 2998, Tacoma, WA 98401-2998. However, notice to the Claims Administrator will not be considered to have been given to and received by the Claims Administrator until physically received.

PLAN SPONSOR IS AGENT

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

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

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

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

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

TAX TREATMENT

The Claims Administrator does not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, the Plan 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 the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes only the following companies: Regence BlueCross BlueShield of Oregon in the state of Oregon, Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For preferred and participating Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For nonparticipating Providers who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For nonparticipating Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator may substitute another payment basis.

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

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

Booklet is the description of the benefits by the group health plan. A group health plan with different benefit plan options may describe them in one Booklet or in separate Booklet's for each alternative benefit plan option.

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

Category 1 means the benefit cost-share level for services received from a Provider:

- that has an effective participating contract with the Claims Administrator, that designates him, her or it as a preferred Provider, who is a member of the Plan Sponsor's chosen Provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage;
- that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a "preferred" Provider), to provide services and supplies to Claimants in accordance with the provisions of this coverage; or
- outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Preferred Provider Organization (PPO) Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.

If the Claims Administrator or one of its Affiliates has more than one Provider network from which the Plan Sponsor may choose for benefits under the Plan, then the Providers contracted with the network selected by the Plan Sponsor will be considered the only preferred Providers for purpose of payment of benefits. For Category 1 reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.

Category 2 means the benefit cost-share level for services received from a Provider:

- that has an effective participating contract with the Claims Administrator, that designates him, her or it as a participating Provider, who is a member of the Plan Sponsor's chosen Provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage;
- that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a "participating" Provider), to provide services and supplies to Claimants in accordance with the provisions of this coverage; or
- outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Participating Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.

For Category 2 reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.

Category 3 means the benefit cost-share level for services received from a Provider that is not preferred or participating. For Category 3 services, You may be billed for balances over the Plan's payment level in addition to any Deductible, Copayment and/or Cost-Sharing amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Claimant means a Participant or a Beneficiary.

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

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. "Significant deviation" means a deviation which impairs the function of the body and includes, but is not limited to:

- the conditions of cleft lip and/or cleft palate;
- webbed fingers or toes;
- sixth fingers or toes;
- defects of metabolism; or
- any other conditions that are medically diagnosed to be Congenital Anomalies.

Contribution means the amount paid or payable by the employer or employee, or a postsecondary educational institution or student, into the Trust Fund.

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

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

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

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home.

Effective Date means the date, following the Claims Administrator's receipt of the enrollment form, as the date coverage begins for You and/or Your Beneficiaries.

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

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

Essential Benefits are determined by the U.S. Department of Health and Human Services (HHS) and are subject to change, but currently include at least the following general categories and the items and services covered within the categories:

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

Family means a Participant and his or her Beneficiaries.

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

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

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

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

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

Illness means a:

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

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

Injury means physical damage to the body caused by:

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

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

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in the Claims Administrator's judgment, Investigational:

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective 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 a particular diagnosed condition, benefits for the medication may be provided when so used.
- 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.

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

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

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

Newborn Children means a child or children born during the term of the Agreement to a parent who is a Participant or spouse of a Participant. Newborn Children also includes adopted newborn infants who are Placed with the Participant within 60 days of the adopted child's date of birth. A child will no longer be a Newborn Child if he or she has a break in coverage of 63 or more days.

Newly Adopted Children means a child or children under the age of 18 who is Placed for adoption with a Participant more than 60 days after the child's date of birth. A child will no longer be a Newly Adopted

Child if he or she has a break in coverage of 63 or more days after Placement for adoption with the Participant.

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

Physician means an individual who is duly licensed to practice medicine and/or surgery in all of its branches or to practice as an osteopathic Physician and/or surgeon.

Placed or Placement means physical Placement in the care of the adoptive Participant. In those circumstances in which such physical Placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Participant signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include, but are not limited to:

- podiatrists;
- psychologists;
- certified nurse midwives;
- certified registered nurse anesthetists;
- dentists (doctor of medical dentistry, doctor of dental surgery, denturist, or a dental hygienist who is permitted by his or her respective state licensing board to independently bill third parties); and
- other professionals practicing within the scope of his or her respective licenses.

Primary Physician or Practitioner means a Physician, osteopathic Physician or Practitioner who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed and is licensed in:

- general practice;
- family practice;
- internal medicine;
- pediatrics;
- geriatrics;
- obstetrics/gynecology (Ob/Gyn);
- naturopath;
- preventive medicine;
- adult medicine; or
- women's health care.

Primary Physician or Practitioner also means any Physician assistant, nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under a Physician, osteopathic Physician or Practitioner who is licensed in the same specialty.

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.

Self-Funded Plan means any single employer plan, public postsecondary educational institution plan, or multiple employer welfare plan, or any other single or multiple employer plan, or any postsecondary educational institution student health benefit plan, other than a plan providing only benefits under title 72, Idaho Code, under which payment for medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by contributions or payments thereto by the employer or employers, or by the employer or employers and the employees, or by a postsecondary educational institution and students at said institution, or students of a postsecondary educational institution, who are not otherwise covered by insurance or contract with a health care service corporation or managed care organization authorized to transact business in this state.

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

Specialist means a Physician or Practitioner who does not otherwise meet the definition of a Primary Physician or Practitioner.

Trust Fund means a Trust Fund established in conjunction with a Self-Funded Plan for receipt of Contributions of employer and employees, postsecondary educational institution and students, and payment of or with respect to health care service costs of beneficiaries.

Trustee means the trustee, whether a single or multiple trustee, of the trust fund.

For more information contact the Claims Administrator at 1 (866) 240-9580 or You can write to P.O. Box 2998, Tacoma, WA 98401-2998

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