

## Summary Plan Description

This Summary Plan Description of the group's health care plan is provided to you as required by the Employee Retirement Income Security Act (ERISA) of 1974. The summary outlines the plan's general operation and claim procedures as well as your rights and obligations under the plan and ERISA.

### NAME OF PLAN

Building Industry Association of Washington

### NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR

Building Industry Association of Washington  
300 Deschutes Way SW, Suite 300  
Tumwater, Washington 98501  
1 (360) 352-7800

### IDENTIFICATION NUMBER

The employer's identification number is 91-6379886. The plan number is 501.

### TYPE OF PLAN

This plan can be described as a welfare plan providing medical, life and accidental death and dismemberment benefits and if selected by the participating employer dental and vision coverage.

### TYPE OF ADMINISTRATION

Administered by the Board of Trustees with the assistance of EPK & Associates, Inc., a contract administrative organization.

### NAME, ADDRESS AND TELEPHONE NUMBER OF ADMINISTRATOR

Board of Trustees  
Building Industry Association of Washington  
c/o EPK & Associates, Inc.  
Eastgate Office Park  
15375 Southeast 30th Place, Suite 380  
Bellevue, Washington 98007  
1 (425) 641-7762  
1 (800) 545-7011

### NAME AND ADDRESS OF TRUSTEES

Bob Moe	Ted Clifton
Karen Say-Valadez	Rick Hjelm

All of the Trustees may be contacted at the following address:

300 Deschutes Way SW, Suite 300  
Tumwater, Washington 98501

### NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Each member of the Board of Trustees is authorized to accept service of legal process on behalf of the Trust.

### ELIGIBILITY

Please refer to the Eligibility and Enrollment provision of this Booklet.

### BENEFITS

Please refer to the description of benefits provided in several sections of this Booklet.

### SOURCES OF CONTRIBUTIONS TO THE PLAN

Benefits of the plan are funded through contributions made by participating member employers and their employees. The percentage of employers and employee contributions may vary between firms.

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## **FUNDING MEDIUM**

Employer and employee contributions are received and held in trust by the Board of Trustees pending payment of rates and administrative expenses. The Board of Trustees pays rates to the following insurers who underwrite and/or provide the plan's benefits.

### **Regence BlueShield**

Customer Service/Correspondence Address  
MS CS B32B  
P.O. Box 1827  
Medford, Oregon 97501-9884  
Customer Service: 1 (888) 370-6156

### **Asuris Northwest Health**

Customer Service/Correspondence address  
MS CS B32B  
P.O. Box 1827  
Medford, OR 97501-9884  
Customer Service: 888-370-6162

### **Kaiser Permanente Foundation of Washington**

P.O. Box 34590  
Seattle, Washington 98124-1590  
Customer Service: 1 (888) 901-4636

### **Delta Dental of Washington**

Customer Service Department  
P.O. Box 75983  
Seattle, Washington 98175-0983  
Customer Service: 1 (800) 554-1907

### **LifeMap Assurance Company**

200 SW Market Street  
P.O. Box 1271, M/S E8L  
Portland, Oregon 97207-1271  
Customer Service: 1 (800) 794-5390

### **First Choice Health EAP**

600 University Street, Suite 1400  
Seattle, WA 98101-3129  
Customer Service: 1 (800) 467-5281

## **STATEMENT OF ERISA RIGHTS**

As a participant in this plan, you are entitled to rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

Under ERISA you may examine without charge or obtain copies upon written request (for which the administrator may make a reasonable charge), at the administrator's office (or at work sites or union halls, if appropriate) all plan documents and other plan information including insurance contracts and collective bargaining agreements. The plan is also required to furnish you with a summary of the plan's annual financial report. If any of these materials are not received within 30 days of your request, you may have the right to file suit in a federal court. The court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the documents, unless the materials were not sent because of matters beyond the control of the plan.

ERISA also imposes duties upon plan fiduciaries (the people responsible for the plan's operation). Fiduciaries must operate the plan prudently and in the interest of plan participants and beneficiaries. It also states that no one may fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for benefits is denied, you must receive a written explanation of the reasons for the denial and you have the right to have the plan review and reconsider your claim. You may also file suit in a federal or state court. If a plan fiduciary is misusing the plan's money or if you are discriminated against for asserting your rights, you may request assistance from the

U.S. Department of Labor or file suit in a state or federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may require the other party to pay these costs; if you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or your rights under ERISA, contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor. If you have any questions about your plan, contact your plan administrator.

**2023 BOOKLET FOR:**



**BUILDING INDUSTRY ASSOCIATION OF WASHINGTON**

**Regence Foundation Plus – F45**

**Group Number: 10000030**

**Regence BlueShield Medical Benefits**



**Regence**

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the BlueCross and BlueShield Association

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

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

## **What is “balance billing” (sometimes called “surprise billing”)?**

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

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

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

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

## **You are protected from balance billing for:**

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### **Emergency Services**

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

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

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

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

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

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

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

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

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

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

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

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

# NONDISCRIMINATION NOTICE

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

## **Regence:**

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

### **Medicare Customer Service**

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

### **Customer Service for all other plans**

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

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

### **Medicare Customer Service**

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

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

Fax: 1-888-309-8784

medicareappeals@regence.com

### **Customer Service for all other plans**

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

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

CS@regence.com

You can also file a civil rights complaint with:

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

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

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

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

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

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



# Introduction

Regence BlueShield

**Street Address:**  
1800 Ninth Avenue  
Seattle, WA 98101

**Claims Address:**  
P.O. Box 1106  
Lewiston, ID 83501-1106

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

**Appeals Address:**  
Attn: Member Appeals  
P.O. Box 1408  
Lewiston, ID 83501

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

This Booklet describes benefits effective **May 1, 2023**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us 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 terms "We," "Us" and "Our" refer to Regence BlueShield and the term "Group" means the association through which Your employer has made arrangements for its employees to participate in this coverage. References to "You" and "Your" refer to the Enrolled Employee and/or Enrolled Dependents. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

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

## CONTACT INFORMATION

**Customer Service:** 1 (888) 370-6156  
(TTY: 711)

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

Contact Customer Service:

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

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

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

**Health Plan Disclosure Information:** You may receive written or electronic copies of the following health plan disclosure information by calling the Customer Service telephone number or access that information through Our Web site at [https://www.regence.com/web/regence\\_individual/member-notices](https://www.regence.com/web/regence_individual/member-notices). Available disclosure information includes, but is not limited to:

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

# Regence Foundation Plus F45

## ACCESSING PROVIDERS

For each benefit, We indicate the Provider You may choose and Your payment amount for each Provider option. See the Definitions Section for a complete description of Categories 1, 2 and 3. You can go to [regence.com](http://regence.com) for further Provider network information.

- **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 Coinsurance 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 Coinsurance 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 Coinsurance. This is referred to as balance billing.

## ADDITIONAL ADVANTAGES OF MEMBERSHIP

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

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

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

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## Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Medical Benefits 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 benefits sections 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 We will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is an individual Deductible amount and a Family Deductible amount.

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

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

If You and Your Enrolled Dependents were covered under a prior Building Industry Association of Washington plan that had a Deductible requirement, We will credit to the Deductible amount of this plan any expenses that were creditable to the Deductible amount of the prior plan for the year covered by this plan.

If Your employer is initially enrolling in the Building Industry Association of Washington, and You and Your Enrolled Dependents were covered under Your employer's prior medical plan that was not administered by the Building Industry Association of Washington, and the prior plan had a Deductible requirement, We will credit to the Deductible amount of this plan the expenses that were creditable to the Deductible amount of the prior plan for that year, provided notification of the amount to be credited is received by Us within 31 days of the Member Employer's effective date on this plan.

### 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.

### COINSURANCE (PERCENTAGE YOU PAY)

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

A preferred or participating Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible, Copayment and/or Coinsurance amount. Nonparticipating Providers may bill You for any balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount (referred to as balance billing).

### **BALANCE BILLING**

Balance billing occurs when You are billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services provided to You by a nonparticipating Provider when the nonparticipating Provider's billed amount is not fully reimbursed by Us. You will not be balance billed for emergency services or for certain non-emergency surgical or ancillary services provided by a nonparticipating Provider at a preferred or participating Hospital or Ambulatory Surgical Center. Non-emergency surgical or ancillary services include anesthesiology, pathology, radiology, laboratory, hospitalist, or surgical services. Any amounts You pay for emergency services or for non-emergency surgical or ancillary services will count toward Your Deductible and Out-of-Pocket Maximum.

### **OUT-OF-POCKET MAXIMUM**

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

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

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

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

### **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 Member's Lifetime and do not renew every Calendar Year.

The Contract is renewed each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. If Your Contract renews on a day other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the plan's renewal date will carry over into the next Contract 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 Contract during the same Calendar Year.

**PREVENTIVE VERSUS DIAGNOSTIC SERVICES**

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

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this 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 being performed or requested.

## Medical Benefits

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

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

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

Reimbursement may be available for new medical supplies, equipment, and devices You purchase from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. New medical supplies, equipment, and devices, such as a breast pump or wheelchair, purchased through an approved Commercial Seller are covered at the 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 an approved Commercial Seller and reimbursable new retail medical supplies, equipment, and devices, visit Our Web site or contact Customer Service.

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

### CASE MANAGEMENT

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

### PREAUTHORIZATION

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

Non-contracted Providers are not required to obtain preauthorization from Us prior to providing 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.

**CALENDAR YEAR DEDUCTIBLES****Per Member:** \$2,000**Per Family:** \$4,000**CALENDAR YEAR OUT-OF-POCKET MAXIMUM****Per Member:** \$7,000**Per Family:** \$14,000**PREVENTIVE CARE AND IMMUNIZATIONS**

Benefits will be covered if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit.

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

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

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

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered the same as any other Illness or Injury. For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit Our Web site or contact Customer Service.

**Preventive Care**

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

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

- routine physical examinations, well-baby care, women's care (including screening for gestational diabetes), and health screenings including screening for obesity in adults with a body mass index (BMI) of 30 kg/m<sup>2</sup> or higher;
- intensive multicomponent behavioral interventions for weight management;
- Provider counseling and prescribed medications for tobacco use cessation;
- preventive mammography services, including tomosynthesis;
- depression screening for all adults, including screening for maternal depression; and
- breastfeeding support and one new non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from a Provider (including a Durable Medical Equipment supplier), or a comparable new breast pump obtained from an approved Commercial Seller, even though that seller is not a Provider.

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

#### Immunizations – Adult

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 You pay any balance of billed charges.

#### Immunizations – Childhood (Through 18 Years of Age)

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 You pay any balance of billed charges.

#### Expanded Immunizations

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

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

#### OFFICE OR URGENT CARE CENTER VISITS – ILLNESS OR INJURY

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: You pay \$40 Copayment per visit.	Payment: You pay \$40 Copayment per visit and You pay 50% of the Allowed Amount.	Payment: You pay \$40 Copayment per visit and You pay 50% of the Allowed Amount, and any balance of billed charges.

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

## RADIOLOGY AND LABORATORY SERVICES

### Inpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 30% 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 may be balance billed.

### Outpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 30% 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 may be balance billed.

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

"Complex imaging" means:

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

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

### OTHER PROFESSIONAL SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, You pay 30% 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 may be balance billed.

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

#### Medical Services and Supplies

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

Additionally, certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) 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 Our Web site or contact Customer Service.

### Professional Inpatient

Professional inpatient or comparable mobile visits for treatment of Illness or Injury. Surgical or ancillary services (including anesthesiology, pathology, radiology, laboratory, or hospitalist services) provided by a Category 2 or 3 Provider at a Category 1 Hospital or Ambulatory Surgical Center are covered at the Category 1 benefit level. Contact Customer Service for further information and guidance.

### Diagnostic Procedures

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

### Surgical Services

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

Treatment of varicose veins is only covered when there is:

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

### Therapeutic Injections

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

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

### ACUPUNCTURE

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> 12 visits per Member per Calendar Year		

Acupuncture visits are covered. Acupuncture visits apply to the Maximum Benefit limit for these services, including acupuncture visits that are applied toward any Deductible. For acupuncture to treat Substance Use Disorder Conditions, refer to the Substance Use Disorder Services benefit.

### AMBULANCE SERVICES

<b>Category: All</b>
<b>Provider: All</b>
<b>Payment:</b> After Deductible, You pay 30% 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 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 Sections. 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 Member 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 Member; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

## BLOOD BANK

<b>Category: All</b>
<b>Provider: All</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.

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

**DENTAL HOSPITALIZATION**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

**DETOXIFICATION**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

**DIABETIC EDUCATION**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

**DIALYSIS****Inpatient**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Inpatient services and supplies for dialysis are covered.

**Outpatient Initial Treatment Period**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Hemodialysis, peritoneal dialysis and hemofiltration and home services and supplies are covered for an initial treatment period when Your Physician prescribes outpatient dialysis, regardless of Your diagnosis. An initial treatment period is 120 days, measured from the first day You receive dialysis treatment. This initial treatment period benefit is available once for each course of continuous or related dialysis care, even if that course of treatment spans two or more Calendar Years.

**Outpatient Supplemental Treatment Period (Following Initial Treatment Period)**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> No charge even if You have not met Your Out-of-Pocket Maximum, and You are not responsible for any balance. We pay 125% of the Medicare allowed amount at time of service.	<b>Payment:</b> No charge even if You have not met Your Out-of-Pocket Maximum, and You are not responsible for any balance. We pay 125% of the Medicare allowed amount at time of service.	<b>Payment:</b> We pay 125% of the Medicare allowed amount at the time of service.  If You are enrolled in Medicare Part B, You pay nothing at Providers that have agreed to accept assignments of Medicare benefits.  If You are not enrolled in Medicare Part B, You pay the balance of billed charges, which will not apply toward the Out-of-Pocket Maximum.

Outpatient hemodialysis, peritoneal dialysis and hemofiltration services and supplies are covered beginning the first day following completion of the initial treatment period when Your Physician prescribes outpatient dialysis, regardless of Your diagnosis, for a period that is longer than the initial treatment period. Your kidney diagnosis may make You Medicare-eligible and, if You are enrolled in additional Medicare Part B on any basis and receive dialysis from a Medicare-participating Provider, You may not be responsible for additional out-of-pocket expenses.

In addition, a Member receiving supplemental dialysis is eligible to have Medicare Part A and Part B premiums reimbursed as an eligible expense for the duration of the Member's dialysis treatment, as long as the Member continues to be enrolled in Medicare Part A and Part B and continues to be eligible for coverage under the Contract. Proof of payment of the Medicare Part A and 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.

**DURABLE MEDICAL EQUIPMENT**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

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

**EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> You pay \$250 Copayment per visit <u>and</u> after Deductible, You pay 30% 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.	<b>Payment:</b> You pay \$250 Copayment per visit <u>and</u> after Deductible, You pay 30% 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.	<b>Payment:</b> You pay \$250 Copayment per visit <u>and</u> after Deductible, You pay 30% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

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

"Stabilization" means to provide Medically Necessary treatment:

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

If You are admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. If services were not covered at the Category 1 benefit level, contact Customer Service for an adjustment to Your claims.

**GENE THERAPY AND ADOPTIVE CELLULAR THERAPY**

Provider: Centers of Excellence	Provider: All Other Providers
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> You pay 100% of the billed charges. Your payment will not be applied toward any Deductible or Out-of-Pocket Maximum.

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

**Travel Expenses**

<b>Payment:</b> You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your Deductible and travel expense limit.
<b>Limit:</b> \$7,500 per Member per course of treatment, including companion(s), for transportation and lodging expenses. Additional limitations included below.

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

- based on the generally accepted course of treatment in the United States, 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 or participating Provider;
- coverage is for the Member and one companion (or two companions if the Member is under the age of 19);
- commercial lodging expenses are limited to the IRS medical expense allowances (currently \$50 per night for the Member, not to exceed \$100 per night for the Member and companion(s) combined); and
- covered transportation expenses to and from the treatment area include only:
  - commercial coach class airfare;
  - commercial coach class train fare; or
  - documented auto mileage (calculated per IRS medical expense allowances).

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

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

**HOME HEALTH CARE**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> 130 visits per Member 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 apply to the Maximum Benefit limit for these services, including home health care visits that are applied toward any Deductible. Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

**HOSPICE CARE**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> 14 inpatient or outpatient respite care days per Member 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 their family during the final stages of illness.

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

**HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER  
Hospital Care**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

**Ambulatory Surgical Center**

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

Services and supplies of a Hospital or an Ambulatory Surgical Center (including Prescription Medications and services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If You are admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. Please contact Customer Service for further information and guidance.

**INFUSION THERAPY**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

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

**MATERNITY CARE**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

### Surrogacy

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

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

### Definitions

The following definition applies to this Maternity Care benefit:

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

### MEDICAL FOODS

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

**MENTAL HEALTH SERVICES**

**Inpatient Services**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

**Outpatient Office/Psychotherapy Visits**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

**Other Outpatient Services**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

**Definitions**

The following definitions apply to this Mental Health Services benefit:

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

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

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

Practitioners in such settings may be covered if they are billed independently and otherwise would be covered.

### NEURODEVELOPMENTAL THERAPY

Category: 1	Category: 2	Category: 3
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> 25 professional visits per Member per Calendar Year		

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

Neurodevelopmental therapy services apply to the Maximum Benefit limit for these services, including neurodevelopmental therapy services that are applied toward any Deductible. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

### NEWBORN CARE

Category: 1	Category: 2	Category: 3
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

### NUTRITIONAL COUNSELING

Category: 1	Category: 2	Category: 3
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> three visits per Member per Calendar Year (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 apply to the Maximum Benefit limit for these services, including nutritional counseling visits that are applied toward any Deductible.

**ORTHOTIC DEVICES**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

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

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

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

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

**PALLIATIVE CARE**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> 30 visits per Member per Calendar Year		

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

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

**PROSTHETIC DEVICES**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, mastectomy bras only for Members who have had a mastectomy, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

**RECONSTRUCTIVE SERVICES AND SUPPLIES**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

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

**REHABILITATION SERVICES****Inpatient Services**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> 30 days per Member per Calendar Year		

**Outpatient Services**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> unlimited		

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

Rehabilitation services apply to the Maximum Benefit limit for these services, including rehabilitation services that are applied toward any Deductible. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

**REPRODUCTIVE HEALTH CARE SERVICES**

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

The following FDA-approved contraceptive devices, products, and services are covered when provided by a Physician or Practitioner:

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

NOTE: Certain FDA-approved prescription and over-the-counter contraceptive drugs, devices, products and services are covered under the Prescription Medications benefit.

**SKILLED NURSING FACILITY**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> 90 inpatient days per Member 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 services apply to the Maximum Benefit limit for these services, including Skilled Nursing Facility services that are applied toward any Deductible.

### SPINAL MANIPULATIONS

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
<b>Payment:</b> You pay \$40 Copayment.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.
<b>Limit:</b> ten spinal manipulations per Member per Calendar Year		

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

### SUBSTANCE USE DISORDER SERVICES

#### Inpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
<b>Payment:</b> After Deductible, You pay 0% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 0% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

#### Outpatient Office/Psychotherapy Visits

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

#### Other Outpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

## Definitions

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

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

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

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

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

## TRANSPLANTS

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

- heart;
- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:

- either autologous (self-donor);
- allogeneic (related or unrelated donor);
- syngeneic (identical twin donor); or
- umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact Our Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit.

**Donor Organ Benefits**

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

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

**VIRTUAL CARE**

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

**Store and Forward Services**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> You pay \$10 Copayment per visit.	<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

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

**Telehealth**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> You pay \$10 Copayment per visit.	<b>Payment:</b> You pay \$40 Copayment per visit.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

**Telemedicine**

<b>Category: 1</b>	<b>Category: 2</b>	<b>Category: 3</b>
<b>Provider: Preferred</b>	<b>Provider: Participating</b>	<b>Provider: Nonparticipating</b>
<b>Payment:</b> After Deductible, You pay 30% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount.	<b>Payment:</b> After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

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

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

## Prescription Medications

This section explains Your benefits 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 Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. To view the Drug List and find medications by tier, visit Our Web site or contact Customer Service.

### PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLE

**Per Member:** \$150

You do not need to meet the Prescription Medication Deductible when You fill a prescription for a Tier 1 medication. You also do not need to meet the Prescription Medication Deductible when You fill a prescription for a Self-Adminstrable Cancer Chemotherapy Medication, a Prescription Medication on the Naloxone Value List, or for insulin or diabetic supplies.

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 in cost between a Brand-Name Medication and its generic equivalent (or a Specialty Medication and its Specialty Biosimilar Medication) does not apply toward the Prescription Medication Deductible. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of any discount or a drug manufacturer coupon will apply toward Your Prescription Medication Deductible unless there is a generic or therapeutic equivalent on Our Drug List.

### COPAYMENTS AND/OR COINSURANCE

After You meet the Prescription Medication Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts at the time of purchase, if the Pharmacy submits the claim electronically. Your Copayment and/or Coinsurance will be applied toward the Out-of-Pocket Maximum.

You are not responsible for any Copayment and/or Coinsurance when You fill Self-Adminstrable Cancer Chemotherapy Medications or prescriptions for medications intended to treat opioid overdose that are on the Naloxone Value List found on Our Web site or by calling Customer Service.

Your Copayment and/or Coinsurance for insulin will not exceed \$35 per 30-day supply or \$105 per 90-day supply. Insulin is not subject to any Deductible, however, Your payments of Copayment and/or Coinsurance for insulin will be applied to the Prescription Medication Deductible.

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

• <b>Tier 1:</b> \$15 Copayment
• <b>Tier 2:</b> \$45 Copayment
• <b>Tier 3:</b> 50% Coinsurance
• <b>Compound Medication:</b> 50% Coinsurance

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

• <b>Tier 1:</b> \$30 Copayment
• <b>Tier 2:</b> \$90 Copayment
• <b>Tier 3:</b> 50% Copayment

- **Compound Medication:** 50% Coinsurance

### **Specialty Medications (for Each 30-Day Supply)**

- **Tier 4:** 50% Coinsurance

### **Emergency Fill**

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

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

### **COVERED PRESCRIPTION MEDICATIONS**

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

### **COVERED PREVENTIVE MEDICATIONS, CONTRACEPTIVES AND IMMUNIZATIONS**

Certain medications, contraceptives, and immunizations are covered as preventive care:

- certain preventive medications as recommended by the USPSTF that are on the Drug List, including, but not limited to, aspirin, fluoride, iron, medications for tobacco use cessation, and pre-exposure prophylaxis (PrEP) for the prevention of HIV for people at a high risk of infection when obtained with a Prescription Order;
- all FDA-approved oral contraceptives (combined pill, extended/continuous use combined pill, and the mini pill), contraceptive products (such as condoms, vaginal rings, patches, diaphragms, sponges,

cervical caps, and spermicide), contraceptive shots or injections, and emergency contraceptives (such as levonorgestrel and ulipristal acetate);

- immunizations for adults and children according to, and as recommended by, the CDC; and
- immunizations for purposes of travel, occupation, or residency in a foreign country.

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications by the USPSTF or HRSA, or for contraceptives or immunizations, as specified above (except for immunizations for the purpose of travel, occupation or residency in a foreign country). NOTE: The applicable Deductible, Copayment and/or Coinsurance as listed in this Prescription Medications Section will apply for preventive medications, contraceptives, and immunizations from a Nonparticipating Pharmacy.

FDA-approved over-the-counter contraceptive drugs, devices, and products are available from a Participating Pharmacy without a prescription and with no cost-sharing. However, You must submit a claim for reimbursement for the purchase of such items when not purchased at a Pharmacy. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us for processing. The Drug Claim Form may be found at <https://regence.myprime.com/v/RBW/COMMERCIAL/en/forms.html>.

Also, if Your Provider believes that Our covered preventive medications are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service.

For a complete list of medications, visit Our Web site or contact Customer Service.

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

## **PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION**

### **Your Prescription Drug Rights**

You have the right to safe and effective Pharmacy services. You also have the right to know what drugs are covered by Your plan and the limits that apply. If You have a question or concern about Your prescription drug benefits, contact Us at 1 (888) 370-6156 or visit Our Web site.

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

### **Preauthorization**

Some Prescription Medications may require preauthorization before they are dispensed. We notify Category 1 and Category 2 Providers and Participating Pharmacies which Prescription Medications require preauthorization. Prescription Medications that require preauthorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require preauthorization will not be covered until they are preauthorized. For a list of medications that require preauthorization or if You have any questions, visit Our Web site or contact Customer Service.

### **Drug List Changes**

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

If You are taking a Prescription Medication while it is removed from the Drug List and its removal was not due to the Prescription Medication being removed from the market, becoming available over-the-counter or issuance of a black box warning by the Federal Drug Administration, We will continue to cover Your Prescription Medication for the time period required to use Our Drug List Exception Process to request

continuation of coverage for the removed Prescription Medication and receive a decision through that process, unless patient safety requires an expedited replacement.

### **Drug List Exception Process**

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

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

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

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

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our Web site. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on Our Web site.

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

### **Your Responsibility for Cost Differences of Chosen Medications**

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

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

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

### **Pharmacy Network Information**

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

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

### **Claims Submitted Electronically**

Participating Pharmacies will submit claims electronically. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, We 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 Coinsurance 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 Coinsurance.

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

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

### **Home Delivery (Mail-Order)**

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

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

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

### **Prescription Medications Dispensed by Excluded Pharmacies**

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

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

### **Refills**

Refills obtained from:

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

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

### **Discounts or Manufacturer Coupons**

Any reduction in Your cost-sharing resulting from the use of any discount or a drug manufacturer coupon will apply toward Your Prescription Medication Deductible and Out-of-Pocket Maximum, unless there is a generic or therapeutic equivalent on Our Drug List. However, if there is a generic or therapeutic equivalent on Our Drug List, the reduction to Your cost-sharing will still apply toward Your Prescription Medication Deductible and Out-of-Pocket Maximum if the Prescription Medication was obtained through the Drug List exception process or step therapy (preauthorization). For more information, visit Our Web site or contact Customer Service.

### **LIMITATIONS**

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

#### **Prescription Medication Supply Limits**

- **30-Day Supply Limit:**
  - **Specialty Medications** – the largest allowable quantity for a Specialty Medication is a 30-day supply. The first fill is allowed at a Pharmacy. Additional fills must be purchased from a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, visit Our Web site or contact Customer Service. Specialty medications are not allowed through Home Delivery Suppliers.
  - **Nonparticipating Pharmacy** – except as specifically provided below, a 30-day supply is the largest allowable quantity of a Prescription Medication that You may purchase from a Nonparticipating Pharmacy and for which a single claim may be submitted. The largest allowable quantity of a covered maintenance medication purchased from a Nonparticipating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
- **90-Day Supply Limit:**
  - **Participating Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Participating Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
  - **Home Delivery (Mail-Order) Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Home Delivery Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
  - **Multiple-Month Supply** – the maximum number of days for a covered Prescription Medication that is packaged in a multiple-month supply and is purchased from a Participating Pharmacy is a 90-day supply (even if the manufacturer packaging includes a larger supply). The Copayment and/or Coinsurance is based on the Prescription Order up to a 34-day supply within that multiple-month supply.
- **Maximum Quantity Limit:**
  - For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the 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 Member'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 We determine the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

## **EXCLUSIONS**

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

### **Biological Sera, Blood or Blood Plasma**

#### **Bulk Powders**

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

#### **Cosmetic Purposes**

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

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

#### **Devices or Appliances**

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

#### **Diagnostic Agents**

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

#### **Digital Therapeutics**

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

#### **Foreign Prescription Medications**

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

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

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

#### **General Anesthetics**

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

#### **Medical Foods**

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

#### **Medications that are Not Considered Self-Administrable**

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

### **Nonprescription Medications**

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

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

Nonprescription medications include, but are not limited to:

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

### **Prescription Medications Dispensed in a Facility**

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

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

### **Prescription Medications Not Approved by the FDA**

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

### **Prescription Medications Not on the Drug List**

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

### **Prescription Medications Not within a Provider's License**

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

### **Prescription Medications with Therapeutic Alternatives**

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

### **Prescription Medications without Examination**

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

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

### **Professional Charges for Administration of Any Medication**

### **Repackaged Medications, Institutional Packs and Clinic Packs**

### **DEFINITIONS**

The following definitions apply to this Prescription Medications Section:

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

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

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

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

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

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

Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to.

Nonparticipating Specialty Pharmacy means a Specialty Pharmacy with which We neither have contract nor have contracted access to any network it belongs to.

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

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

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

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

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

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;

- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or
- are specifically included on Our Drug List.

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

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

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

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

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

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

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

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Drug List that is approved for coverage at the Tier 3 benefit level. Substituted Medication also means a Specialty Medication not on the Drug List that is approved for coverage at the Tier 4 benefit level.

Tier 1 means medications that provide the highest overall value. Mostly includes Generic Medications but may include some Brand-Name Medications.

Tier 2 means medications that provide moderate overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 3 means medications that provide lower overall value. Usually includes Brand-Name Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

Tier 4 means Specialty Medications that provide moderate overall value.

## General Exclusions

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

### SPECIFIC EXCLUSIONS

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

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

### 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**

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;
- employee assistance program services; and
- job skills or sensitivity training.

### **Conditions Caused by Active Participation in a War or Insurrection**

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

### **Conditions Incurred in or Aggravated During Performances in the Uniformed Services**

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

### **Continuous Glucose Monitors**

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

### **Cosmetic Services and Supplies**

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

### **Counseling in the Absence of Illness**

Except as required by law, counseling in the absence of illness is not covered.

### **Custodial Care**

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

### **Dental Services**

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

### **Expenses Before Coverage Begins or After Coverage Ends**

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

### **Family Counseling**

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

### **Family Planning**

Over-the-counter contraceptive supplies, except as covered in the Prescription Medications Section.

### **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 Us, benefits that are covered (or would be covered in the absence of this plan) by any federal, state or government program are not covered.

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

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

### **Hearing Aids and Other Devices**

Except for cochlear implants, hearing aids (externally worn or surgically implanted) or other hearing devices, including implantation and associated surgical services, are not covered.

### **Hypnotherapy and Hypnosis Services**

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

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

### **Illegal Activity**

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

### **Illegal Services, Substances and Supplies**

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

### **Individualized Education Program (IEP)**

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

### **Infertility**

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

- surgery;
- uterine transplants;
- fertility drugs; and
- other medications associated with fertility treatment.

### **Investigational Services**

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

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

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

### **Liposuction for the Treatment of Lipedema**

#### **Motor Vehicle No-Fault Coverage**

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

#### **Non-Direct Patient Care**

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

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

#### **Obesity or Weight Reduction/Control**

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

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

#### **Orthognathic Surgery**

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

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

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

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

#### **Personal Items**

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

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

### **Physical Exercise Programs and Equipment**

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

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

### **Private-Duty Nursing**

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

### **Reversals of Sterilizations**

Services and supplies related to reversals of sterilization.

### **Routine Foot Care**

### **Routine Hearing Examinations**

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

Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate a Member, 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 Member'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, except as provided in the Office or Urgent Care Center Visits benefit.

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:
  - marriage;
  - insurance;
  - occupational injury benefits;
  - licensure; or
  - certification.
- travel, immigration or emigration.

### **Sexual Dysfunction**

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

### **Surrogacy**

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

### **Temporomandibular Joint (TMJ) Disorder Treatment**

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

### **Third-Party Liability**

Services and supplies for treatment of illness, 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.

### **Varicose Vein Treatment**

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

### **Vision Care**

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

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

**Wigs**

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

**Work-Related Conditions**

Except when a Member 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 Member will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

## Contract and Claims Administration

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

### SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

#### 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 Us for processing Your claim.

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

#### Category 3 Claims and Reimbursement

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

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

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

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

#### Timely Filing of Claims

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

#### Claim Determinations

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

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

### **CONTINUITY OF CARE**

You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the Category 1 or Category 2 benefit level, if one of the following situations apply:

- Your Provider was a contracted preferred or participating Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud); or
- Your Group's Contract with Us is terminated for reasons other than fraud, and your Group's new health plan does not include Your preferred or participating Provider in its network.

To qualify for continued coverage, You must be:

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

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

### **OUT-OF-AREA SERVICES**

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside the geographic area We serve, 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 of the geographic area We serve, You may receive it from Providers as described below. Providers contracted with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the preferred Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the participating Provider level and may bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Some Providers ("nonparticipating Providers") don't contract with the Host Blue. We further explain below how We pay these different kinds of Providers.

### **BlueCard Program**

Under the BlueCard Program, when You receive Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its preferred or participating Providers.

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

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price We have 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 under 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 Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

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

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

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

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

### **Nonparticipating Providers Outside Our Service Area**

- **Your Liability Calculation.** When Covered Services are provided outside of Our 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 We 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, We may use other payment methods, such as billed covered charges, the payment We would make if the health care services had been obtained within Our Service Area, or a special negotiated payment to determine the amount We 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 We will make for the Covered Services as set forth in this paragraph.

### **BLUE CROSS BLUE SHIELD GLOBAL® CORE**

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

## **CLAIMS RECOVERY**

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

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

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

## **RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY**

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

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

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

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

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

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

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

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

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

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

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

- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to the plan's right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- Further, You or Your representative give Us a lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by law to the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- You or Your representative also agrees to pay from any recovery, settlement, judgment or other source of compensation, any and all amounts due Us as reimbursement for the full cost of all benefits, to the extent permitted by law, associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Injury or Illness through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which We have provided benefits. This is true regardless of whether:
  - the Third Party or the Third Party's insurer admits liability;
  - the health care expenses are itemized or expressly excluded in the Third-Party recovery; or
  - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Contract. The amount to be held in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.
- Any benefits We advance are solely to assist You. By advancing such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

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

### **No-Fault Coverage**

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

### **Motor Vehicle Coverage**

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

amount necessary to fully compensate You, along with all other payments You receive to compensate You for Your Injuries, losses or damages, for those Injuries, losses or damages.

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

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

### **Workers' Compensation**

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

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

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

### **Fees and Expenses**

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

### **COORDINATION OF BENEFITS**

The Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan. This section is a summary of only a few of the provisions of Your health plan to help You understand COB, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in the Group's Contract, which determines Your benefits.

Coordination of benefits is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common situations. If Your situation is not described, read the Group's Contract or contact the Washington State Insurance Department.

### **Double Coverage**

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have Family coverage through both employers. When You are covered by more than one health plan, Washington state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each health plan should pay when You have a claim. The goal is to ensure that the combined payments of all plans do not add up to more than Your covered health care expenses.

### **Primary or Secondary?**

You will be asked to identify all the plans that cover members of Your Family. To avoid delays in claim processing, if You are covered by more than one plan, You should promptly report to Your Providers and plans any changes in Your coverage. We need this information to determine whether We are the "primary" or "secondary" benefit payer. The primary plan always pays first when You have a claim. Any plan that does not contain Your state's COB rules will always be primary.

### **When This Plan is Primary**

If You or a family member is covered under another plan in addition to this one, We will be primary when:

- **Your Own Expenses.** The claim is for Your own health care expenses, unless You are covered by Medicare and both You and Your spouse are retired.
- **Your Spouse's Expenses.** The claim is for Your spouse, who is covered by Medicare, and You are not both retired.
- **Your Child's Expenses.** The claim is for the health care expenses of Your child who is covered by this plan; and
  - You are married and Your birthday is earlier in the year than Your spouse's, or You are living with another individual (regardless of whether or not You have ever been married to that individual) and Your birthday is earlier in the year than that other individual's birthday. This is known as the "birthday rule"; or
  - You are separated or divorced, and You have informed us of a court decree that makes You responsible for the child's health care expenses; or
  - There is no court decree, but You have custody of the child.
- **Other Situations.** We will be primary when any other provisions of state or federal law require Us to be.

### **How We Pay Claims When We Are Primary**

When We are the primary plan, We will pay the benefits according to the terms of the Contract, just as if You had no other health care coverage under any other plan.

### **How We Pay Claims When We Are Secondary**

When We are knowingly the secondary plan, We will make payment promptly after receiving payment information from Your primary plan. As Your secondary plan, We may ask You and/or Your Provider for information in order to make payment. To expedite payment, be sure that You and/or Your Provider supply all required information in a timely manner.

If Your primary plan fails to pay within 60 calendar days of receiving all necessary information from You and Your Provider, You and/or Your Provider may submit the claim to Us as if We were the primary plan. In such situations, We are required to pay those claims within 30 calendar days of receiving Your claim and the notice that Your primary plan has not paid. **This provision does not apply if Medicare is the primary plan.**

We may recover from the primary plan any excess amount paid under the Right of Recovery provision.

- If there is a difference between the amounts the plans allow, We will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the amount called for in Our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their Providers as do some other plans.
- We will determine Our payment by subtracting the amount paid by the primary plan from the amount We would have paid if We had been the primary plan. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to 100% of the total allowable expense (the highest of the amounts allowed under each plan involved) for Your claim. We are not required to pay an amount in excess of Our maximum benefits, plus any accrued savings. If Your Provider negotiates reimbursement amounts with the plan(s) for the service provided, Your Provider may not bill You for any excess amounts once the Provider has received payment for the highest of the negotiated amounts. When Our deductible is fully credited, We will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that We do not cover, We may pay for those expenses.

### **Facility of Payment**

If payments that should have been made under This Plan are made by another Plan, We have the right, at Our discretion, to remit to the other Plan the amount We determine appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, We are fully discharged from liability under This Plan.

### **Right of Recovery**

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

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

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

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

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

## Appeal and Grievance Process

This provision describes the process for submitting an appeal or Grievance. You may submit an appeal, as detailed below, if You or Your Representative want a review of a claim denial or other dispute. There is one level of Internal Appeal, in addition to an External Review with an Independent Review Organization. Situations that require a faster decision may also qualify for an Expedited Appeal. For complaints not involving an appeal, You may submit a Grievance as detailed under the Grievance Process provision.

NOTE: Records or other materials that include others' medical or health records and other personal health information should not be submitted for appeals or Grievances.

### WHAT YOU MAY APPEAL

You may appeal disputes regarding:

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

Appeals must be pursued within 180 days of Your receipt of Our determination (Internal Appeals must be pursued within 180 days of Your receipt of Our original adverse decision that You are appealing). If You don't appeal within this time period, You will not be able to pursue an appeal. You have the right to review copies of all documents, records and information relevant to any claim that is the subject of the appeal, upon request and free of charge.

Appeals can be initiated through either a written or verbal request using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Sign into your account at <b>regence.com</b> Navigate to Appeals and appeal online
Email	MemberAppeals@regence.com
Fax	1 (888) 496-1542
Phone	Call the Customer Service phone number on your member identification card
Mail	Attn: Member Appeals Regence BlueShield P.O. Box 1408 Lewiston, ID 83501

When We receive an appeal request, We will send a written acknowledgement within 72 hours of receiving the request. If We reverse Our initial Adverse Benefit Determination, which We may do at any time during the review process, We will provide You with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

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

#### **APPEAL DETERMINATION TIMING**

<b>Type of Appeal</b>	<b>When to Expect a Response</b>
Internal Appeal involving a Post-Service investigational issue	In writing, within 20 working days of Our receipt of the appeal.
Internal Appeal involving all other issues	In writing, within 14 days of Our receipt of the appeal.
Internal Expedited Appeal	Verbal notice as soon as possible, but no later than 72 hours of receipt of the appeal, followed by written notice within 72 hours of the date of the decision.
Voluntary External Review by an Independent Review Organization (IRO)	In writing, within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request.
Voluntary Expedited Review by an Independent Review Organization (IRO)	Verbal notice as soon as possible, but no later than 72 hours of the IRO's receipt of the necessary information, followed by written notice within 48 hours of the verbal notice.

#### **INTERNAL APPEALS**

Internal Appeals are reviewed by an employee or employees who were not involved in the adverse decision. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony. In appeals that require medical judgment, the review is completed by Our staff of health care professionals. You will be notified if, for good cause, We require additional time. An extension cannot delay the decision beyond 30 days without Your informed written consent.

#### **VOLUNTARY EXTERNAL REVIEW – IRO**

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

We coordinate voluntary External Review, but the decision is made by an IRO at no cost to You. We will provide the IRO with the appeal documentation, which is available to You or Your Provider upon request. You will also be provided five business days to submit additional written information directly to the IRO for consideration. Choosing the voluntary External Review as the final level to determine an appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law. The voluntary External Review by an IRO is optional and You should know that other forums may be utilized as the final level of review to resolve a dispute. This includes, but is not limited to, civil action under Section 502(a) of ERISA, where applicable.

#### **EXPEDITED APPEALS**

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

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

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

You may request concurrent expedited internal and external reviews of Adverse Benefit Determinations. When concurrent expedited reviews are requested, the requisite timelines will be applied concurrently, not consecutively.

**Internal Expedited Appeal**

The internal Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Internal Expedited Appeals are reviewed by employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. Reviewers include an appropriate clinical peer in the same or similar specialty as would typically manage the case. You or Your Representative will be given the opportunity (within the constraints of the Expedited Appeals time frame) to provide written materials, including written testimony on Your behalf.

**Voluntary Expedited Review – IRO**

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

We coordinate voluntary Expedited Reviews, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Expedited Review documentation, which is available to You or Your Provider upon request. Choosing the voluntary Expedited Review as the final level to determine an appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law. The voluntary Expedited Review by an IRO is optional and You should know that other forums may be used as the final level of Expedited Appeal to resolve a dispute You have with Us, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

**GRIEVANCE PROCESS**

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

Method of Request	Contact Information
Phone	Call Customer Service at 1 (888) 370-6156
Mail	P.O. Box 1827, MS CS B32B Medford, OR 97501-9884

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

**ASSISTANCE**

For assistance with internal claims, appeals, and the external review process, contact:

Office of the Insurance Commissioner  
Consumer Protection Division  
PO Box 40256  
Olympia, WA 98504-0256

Toll Free: 1 (800) 562-6900  
 TDD: 1 (360) 586-0241  
 Olympia: 1 (360) 725-7080  
 Fax: 1 (360) 586-2018  
 E-mail: [cap@oic.wa.gov](mailto:cap@oic.wa.gov)  
 Web: [www.insurance.wa.gov](http://www.insurance.wa.gov)

## DEFINITIONS

The following definitions apply to this Appeal and Grievance Process section:

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

Expedited Appeal means an appeal where:

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

Experimental or Investigational means a Health Intervention that We have classified as Experimental or Investigational. For a full definition of Experimental and Investigational, refer to Experimental/Investigational in the Definitions Section.

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

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

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

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

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

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

Representative means someone who represents You for the appeal or the Grievance. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information. No authorization is required from the parent(s) or legal guardian of a Member who is a dependent child and is less than 13 years old. For Expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative without additional authorization. Even if You have previously designated a person as Your Representative for a

previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each appeal level). If no authorization exists and is not received in the course of the appeal, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

## Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual open enrollment period. It describes when coverage under the Contract begins for You and/or Your eligible dependents. Payment of any corresponding monthly premiums 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 ten days of initially becoming eligible for coverage per the eligibility requirements in effect with the Group and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

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 open 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 a Member Employer long enough to satisfy any required probationary period.

### Dependents

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

- The person to whom You are legally married (spouse).
- Your registered domestic partner.
- Your non-registered domestic partner when the Member Employer has a domestic partner policy on file with the Group Representative. For more information, please contact Your employer or the Group Representative.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
  - Your (or Your spouse's or Your domestic partner's) natural child, stepchild, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
  - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
  - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental or physical disability that began before the child's 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
  - the child is an enrolled child immediately before their 26th birthday; or
  - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as Your dependent on group coverage since that birthday.

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

### NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a non-registered domestic partner, an affidavit of qualifying

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

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

### **SPECIAL ENROLLMENT**

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

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

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

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

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

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

becoming eligible for premium assistance under Medicaid or Children's Health Insurance Program (CHIP), or the Washington State Department of Social and Health Services (DSHS) determination that it is cost-effective for an eligible dependent to have coverage under the Contract, You have 60 days from the date of the qualifying event to enroll):

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

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

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

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

### **ANNUAL OPEN ENROLLMENT PERIOD**

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

## When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. You must notify Your employer and/or the Group Representative within ten days of the date on which an Enrolled Dependent 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 Enrolled Dependent's coverage under the Contract for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Contract was in effect.

### **CONTRACT TERMINATION**

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

### **MEMBER EMPLOYER TERMINATION**

If Your employer ceases to be a Member Employer, coverage ends for You and Your Enrolled Dependents on the date Your employer ceases to participate under the Contract.

### **WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE**

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the last day of the month in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the COBRA Continuation of Coverage, Conversion, 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 Contract, coverage will end for You and all Enrolled Dependents on the last day of the month in which eligibility ends.

#### **Nonpayment of Premium**

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

### **WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE**

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Enrolled Dependents on the last day of the month in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the COBRA Continuation of Coverage, Conversion, 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 month following the date a divorce or annulment is final.

#### **Death of the Enrolled Employee**

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

#### **Termination of Domestic Partnership**

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the month following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. This termination provision does

not apply to any termination of domestic partnership that occurs as a matter of law because the parties to the domestic partnership enter into a marriage (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage).

### **Loss of Dependent Status**

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

### **OTHER CAUSES OF TERMINATION**

Members terminated for the following reason may be able to continue coverage under the Contract according to the COBRA Continuation of Coverage provision.

#### **Fraudulent Use of Benefits**

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

#### **Fraud or Misrepresentation in Application**

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

### **FAMILY AND MEDICAL LEAVE**

If Your employer grants You a leave of absence under an applicable state or federal family and medical leave law the following rules will apply. The federal Family and Medical Leave Act is generally applicable to private employers of 50 or more employees and public employers of any size. But state law may be applicable more broadly. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the applicable law:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the leave for a period of up to 12 weeks, or as required by law, during a 12-month period for one of the following:
  - to care for Your newly born child;
  - to care for Your spouse, domestic partner, 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 leave, You must continue to pay Your portion of the monthly premium through Your employer to the Group Representative on time. The provisions described here will not be available if the Contract terminates or Your employer ceases to be a Member Employer.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the leave. In order to reenroll after You return from a 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 Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the leave and You will not have to re-serve any probationary period under the Contract.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to leave does not constitute a qualifying event for COBRA continuation. However, a person

who does not return to active employment following 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 leave.

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

### **LEAVE OF ABSENCE**

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

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

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

## 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 is available to Your Enrolled Dependents if they involuntarily lose eligibility because:

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

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced.

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 Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Member Employer contributes toward the premiums 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 Enrolled Dependent's rights with COBRA, You or Your Enrolled Dependents must inform the Group Representative in writing within 60 days of:

- Your divorce or annulment, termination of registered domestic partnership or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Enrolled Dependent were 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 Enrolled Dependent is no longer disabled per Social Security, You or Your Enrolled Dependent must provide the Group Representative notice of that determination within 30 days of the date it is made.)

The Member Employer also must meet certain notification, election and payment deadline requirements. It is very important that You keep Your employer and the Group Representative informed of Your current address.

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

### Notice

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

## Conversion

When eligibility under the Contract terminates, You will be allowed to enroll under one of Our conversion plans if offered in Your Service Area and You are under age 65 and ineligible for Medicare.

We must receive Your application for one of Our conversion plans within 31 days following termination of coverage under this Contract. You will not be required to complete a health statement. Conversion plan benefits will be the standard individual medical and Hospital benefits coverage in effect at the date of conversion that We customarily offer to Members upon termination of coverage. Rates under the conversion plan will likely be higher than this Contract and benefits will likely be substantially less. Additional information is available by calling Customer Service.

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

## Other Continuation Options

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

### **Availability of Other Coverage**

When eligibility under the Contract 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 Us. The policy or plan will have equal or lesser benefits than this coverage.

### **Strike, Lockout or Other Labor Dispute**

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

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

## 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 Contract must be filed in a court in the state of Washington.

### ERISA (IF APPLICABLE)

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

The Group intends that the Contract be maintained for the exclusive benefit of the employees and intends to continue this coverage indefinitely. However, the Group reserves the right to discontinue or change this coverage at any time. If the Contract is terminated for any reason and is not replaced with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

### Rights and Protection

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

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events.
- Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.
- Receive a certificate of creditable coverage from group plans and health insurance issuers, free of charge, when the employee loses coverage, becomes entitled to COBRA continuation, exhausts COBRA continuation, and upon request within 24 months after losing coverage.

### Duties

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

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

### Denied Claims

If an employee has a claim for benefits which is denied (or ignored) in whole or in part, the employee may file suit in a state or federal court. An employee may also do so if they disagree with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting their rights, employees

may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, they should contact the plan administrator.

### **If You Need More ERISA Information**

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

### **GOVERNING LAW AND BENEFIT ADMINISTRATION**

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

### **GROUP IS AGENT**

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

### **LIMITATIONS ON LIABILITY**

In all cases, You have the exclusive right to choose a health care Provider. Since We do not provide any health care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither Our employees nor agents. We are responsible for the quality of health care You receive only as provided by law. In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Booklet by reason of epidemic, disaster or other cause or condition beyond Our control.

### **MODIFICATION OF CONTRACT**

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

### **NO WAIVER**

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

**NONASSIGNMENT**

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

**NOTICES**

Any notice to Members required in the Contract will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee will be addressed to the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be mailed to Our Customer Service address. However, notice to Us will not be considered to have been given to and received by Us until physically received by Us.

**PREMIUMS**

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

**RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION**

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

**REPRESENTATIONS ARE NOT WARRANTIES**

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

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS**

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

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

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

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

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

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

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

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

#### **TAX TREATMENT**

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

#### **WHEN BENEFITS ARE AVAILABLE**

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

- the person is eligible to be covered according to the eligibility provisions in the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person for the current month has been paid by the Group on a timely basis.

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

#### **WOMEN'S HEALTH AND CANCER RIGHTS**

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

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

## Definitions

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

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

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 (non-contracted) Providers, the amount We have determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

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

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

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

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

Category 1 means the benefit reimbursement level for services that are received from a contracted Provider with Us in Your Provider network who provides services and supplies to Members in accordance with the provisions of this coverage. Your Provider network is Preferred and may include Our Affiliates. Category 1 also means a Provider outside the area that We or one of Our Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program as a preferred Provider. Refer to the Out-of-Area Services Section for additional details. Category 1 reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 1 Providers include only Our identified Centers of Excellence for the particular therapy.

Category 2 means the benefit reimbursement level for services that are received from a contracted Provider with Us in Your Provider network who provides services and supplies to Members in accordance with the provisions of this coverage. Your Provider network is Participating and may include Our Affiliates. Category 2 also means a Provider outside the area that We or one of Our Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program as a participating Provider. Refer to the Out-of-Area Services Section for additional details. Category 2 reimbursement is generally a lower payment level than Category 1, but You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 2 Providers include any Provider that is not one of Our identified Centers of Excellence for the particular therapy.

Category 3 means the benefit reimbursement level for services that are received from a Provider that is a non-contracted (nonparticipating) Provider. Category 3 reimbursement is generally the lowest payment

level of all categories, and You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Category 3 Providers include any Provider that is not one of Our identified Centers of Excellence for the particular therapy.

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

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in this 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 Member's home.

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

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

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

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

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

Experimental/Investigational means a Health Intervention that We have classified as Experimental or Investigational. We will review Scientific Evidence from well-designed clinical studies found in Peer-Reviewed Medical Literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Experimental or Investigational. A Health Intervention not meeting all of the following criteria, is, in Our judgment, Experimental or Investigational:

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

Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:

- Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
  - Standard Reference Compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, illness or injury, length of life, ability to function and quality of life.
  - The Health Intervention must improve net Health Outcome.
  - Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
  - The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
  - The improvement must be attainable outside the laboratory or clinical research setting.

Upon receipt of a fully documented claim or request for preauthorization related to a possible Experimental or Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Contact Us for details on the information needed to satisfy the fully documented claim or request requirement. You may also have the right to an Expedited Appeal. Refer to the Appeal Process Section for additional information on the Appeal process.

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

Family means an Enrolled Employee and any Enrolled Dependents.

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

Group Representative means the Building Industry Association of Washington administrator who has been designated by the Group to act as its agent to remit the premium of all Member Employers to Us and to give and receive notices under this plan.

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.

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

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

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

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

Member means an Enrolled Employee or an Enrolled Dependent.

Member Employer means a business entity qualifying for membership or participation in the Group and choosing to participate under the Contract to provide coverage to its employees and their dependents as Enrolled Employees and Enrolled Dependents, respectively.

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

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

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

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

Provider means:

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

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

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

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

Service Area means the geographic area in Washington state where We have been authorized by the State of Washington to sell and market this plan. The Service Area for this plan is the following counties:

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

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

## Appendix: Value-Added Services

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

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

### **KIDNEY HEALTH MANAGEMENT**

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

### **NURSE ADVICE**

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

### **PREGNANCY PROGRAM**

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

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

### **REGENCE EMPOWER**

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

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

## Summary Plan Description

This Summary Plan Description of the group's health care plan is provided to you as required by the Employee Retirement Income Security Act (ERISA) of 1974. The summary outlines the plan's general operation and claim procedures as well as your rights and obligations under the plan and ERISA.

### NAME OF PLAN

Building Industry Association of Washington

### NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR

Building Industry Association of Washington  
300 Deschutes Way SW, Suite 300  
Tumwater, Washington 98501  
1 (360) 352-7800

### IDENTIFICATION NUMBER

The employer's identification number is 91-6379886. The plan number is 501.

### TYPE OF PLAN

This plan can be described as a welfare plan providing medical, life and accidental death and dismemberment benefits and if selected by the participating employer dental and vision coverage.

### TYPE OF ADMINISTRATION

Administered by the Board of Trustees with the assistance of EPK & Associates, Inc., a contract administrative organization.

### NAME, ADDRESS AND TELEPHONE NUMBER OF ADMINISTRATOR

Board of Trustees  
Building Industry Association of Washington  
c/o EPK & Associates, Inc.  
Eastgate Office Park  
15375 Southeast 30th Place, Suite 380  
Bellevue, Washington 98007  
1 (425) 641-7762  
1 (800) 545-7011

### NAME AND ADDRESS OF TRUSTEES

Bob Moe	Ted Clifton
Karen Say-Valadez	Rick Hjelm

All of the Trustees may be contacted at the following address:

300 Deschutes Way SW, Suite 300  
Tumwater, Washington 98501

### NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Each member of the Board of Trustees is authorized to accept service of legal process on behalf of the Trust.

### ELIGIBILITY

Please refer to the Eligibility and Enrollment provision of this Booklet.

### BENEFITS

Please refer to the description of benefits provided in several sections of this Booklet.

### SOURCES OF CONTRIBUTIONS TO THE PLAN

Benefits of the plan are funded through contributions made by participating member employers and their employees. The percentage of employers and employee contributions may vary between firms.

**FUNDING MEDIUM**

Employer and employee contributions are received and held in trust by the Board of Trustees pending payment of rates and administrative expenses. The Board of Trustees pays rates to the following insurers who underwrite and/or provide the Plan's benefits.

**Regence BlueShield**

Customer Service/Correspondence Address  
MS CS B32B  
P.O. Box 1827  
Medford, Oregon 97501-9884  
Customer Service: 1 (888) 370-6156

**Kaiser Permanente Foundation of Washington**

P.O. Box 34590  
Seattle, Washington 98124-1590  
Customer Service: 1 (888) 901-4636

**Delta Dental of Washington**

Customer Service Department  
P.O. Box 75983  
Seattle, Washington 98175-0983  
Customer Service: 1 (800) 554-1907

**LifeMap Assurance Company**

200 SW Market Street  
P.O. Box 1271, M/S E8L  
Portland, Oregon 97207-1271  
Customer Service: 1 (800) 794-5390

**First Choice Health EAP**

600 University Street, Suite 1400  
Seattle, WA 98101-3129  
Customer Service: 1 (800) 467-5281

**STATEMENT OF ERISA RIGHTS**

As a participant in this plan, you are entitled to rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

Under ERISA you may examine without charge or obtain copies upon written request (for which the administrator may make a reasonable charge), at the administrator's office (or at work sites or union halls, if appropriate) all plan documents and other plan information including insurance contracts and collective bargaining agreements. The plan is also required to furnish you with a summary of the plan's annual financial report. If any of these materials are not received within 30 days of your request, you may have the right to file suit in a federal court. The court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the documents, unless the materials were not sent because of matters beyond the control of the plan.

ERISA also imposes duties upon plan fiduciaries (the people responsible for the plan's operation). Fiduciaries must operate the plan prudently and in the interest of plan participants and beneficiaries. It also states that no one may fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for benefits is denied, you must receive a written explanation of the reasons for the denial and you have the right to have the plan review and reconsider your claim. You may also file suit in a federal or state court. If a plan fiduciary is misusing the plan's money or if you are discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or file suit in a state or federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may require the other party to pay these costs; if you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or your rights under ERISA, contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor. If you have any questions about your plan, contact your plan administrator.

**For more information call Us at 1 (888) 370-6156**

**regence.com**

*This plan arranged by:*



EPK & Associates, Inc.  
15375 Southeast 30th Place, Suite 380  
Bellevue, WA 98007  
1 (425) 641-7762 or 1 (800) 545-7011  
FAX: 1 (425) 641-8114  
Email: [admin@epkbenefits.com](mailto:admin@epkbenefits.com)



**Regence**

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the BlueCross and BlueShield Association

# Delta Dental PPO<sup>SM</sup>

National Coverage Plan



**Building Industry Association of Washington dba  
BIAW Trust**

Delta Dental of Washington

**Plan Number: 01096 – Voluntary 30**

**Effective Date: May 1, 2022 – April 30, 2024**

Welcome to your Dental Plan, administered by Delta Dental of Washington, a founding member of the nationwide Delta Dental Plans Association.

We believe everyone can enjoy good oral and overall health, with no one left behind. It drives everything we do and has been our sole focus for over 60 years.

Your plan is a resource to make it easy for you to care for your smile. This benefit booklet summarizes your coverage and describes how your benefits may be used. Understanding your benefits is the first step to getting the most from your dental plan. Review this booklet before you visit your Dentist and keep it for your reference.

You deserve a healthy smile. We're happy to help you protect it.

## **Questions Regarding Your Plan**

If you have questions regarding your dental benefits plan, please call or email our Customer Service Department at:

800-554-1907

CService@DeltaDentalWA.com

Written inquiries may be sent to:

Delta Dental of Washington

Customer Service Department

P.O. Box 75983

Seattle, WA 98175-0983

For the most current listing of Delta Dental Participating Dentists, visit our online directory at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com) or call us at 800-554-1907.

## **Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-Blind or Speech-Disabled**

Communication with Delta Dental of Washington for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with Delta Dental of Washington through specially trained communications assistants.

Dial 711 (the statewide telephone relay number) or 800-833-6384 to connect with a Washington Relay Service communications assistant. Ask them to dial Delta Dental of Washington Customer Service at 800-554-1907. They will then relay the conversation between you and our customer service representatives.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

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**Section A – Summary of Benefits**

**Reimbursement Levels for Allowable Benefits**

**In-Network – Delta Dental PPO Dentists**

Class I .....	100%
Class II .....	80%
Class III .....	50%*
Annual Deductible per Person .....	\$50
Annual Deductible — Family Maximum .....	\$150

**Out-of-Network – Non-Delta Dental PPO**

Class I .....	100%
Class II .....	80%
Class III .....	50%*
Annual Deductible per Person .....	\$50
Annual Deductible — Family Maximum .....	\$150

***\*There is a six-month waiting period for all Class III Benefits.***

## Plan Maximum

Annual Plan Maximum per Person ..... \$1,500

The payment level for covered dental expenses arising as a direct result of an accidental injury is 100 percent, up to the unused Plan Maximum.

All Enrolled Employees and Enrolled Dependents are eligible for Class I, Class II, Class III Covered Dental Benefits, and accidental injury benefits.

The annual deductible is waived for:

- ◇ Class I Covered Dental Benefits.
- ◇ Accidental Injury Benefits.

## How to use your Plan

The best way to take full advantage of your dental Plan is to know its features. You can learn them by reading this benefit booklet before you go to the Dentist. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions. If you have questions or do not understand something, please give us a call at 800-554-1907. We're more than happy to help.

Consult your provider regarding any charges that may be your responsibility before treatment begins.

## Coinsurance

DDWA will pay a percentage of the cost of your treatment and you are responsible for paying the allowable balance. The part you pay is called the coinsurance. If your plan has a deductible, you are responsible for the coinsurance even after a deductible is met.

Please see your "Reimbursement Levels for Allowable Benefits" under the "Summary of Benefits" section for details on the coinsurance required by your plan.

## Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this Plan, the benefit period is the 12-month period starting the first day of January and ending the last day of December.

## Plan Maximum

The Plan Maximum is the maximum dollar amount DDWA will pay toward the cost of dental care within a specific benefit period. The maximum amount payable for Covered Dental Benefits in each benefit period is listed in the "Summary of Benefits" section in this booklet.

Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed, also known as the seat date. Amounts paid for such procedures will be applied to the Plan Maximum based on the incurred date.

## Plan Deductible

Your Plan has a deductible, which can be found in the "Summary of Benefits" section. This means that from the first payment or payments DDWA makes for Covered Dental Benefits, a deduction is taken. This deduction is owed to the provider by you. Once an Enrolled Person has satisfied the deductible during the benefit period, no further deduction will be taken for that Enrolled Person until the next benefit period.

Your family maximum is also listed in the "Summary of Benefits" section. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period.

## **Reimbursement Levels**

Your dental Plan offers different classes of covered treatment. Each class also specifies limitations and exclusions. For more information about reimbursement levels for your plan, see the “Summary of Benefits” section in the front of this benefit booklet.

Refer to the “Benefits Covered by Your Plan” section of this benefit booklet for specific Covered Dental Benefits under this Plan.

## Section B – Your Benefits

### Benefits Covered By Your Plan

The following are the Covered Dental Benefits under this Plan and are subject to the limitations and exclusions (refer also to “General Exclusions” section) contained in this benefit booklet. Such benefits (as defined) are available only when provided by a licensed Dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

Note: Please be sure to consult your provider before treatment begins regarding any charges that may be your responsibility.

The amounts payable by DDWA for Covered Dental Benefits are described in the “Summary of Benefits” section of this benefit booklet.

### Class I Benefits

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#### Class I Diagnostic

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##### Covered Dental Benefits

- ◆ Comprehensive, or detailed and extensive oral evaluation.
- ◆ Diagnostic evaluation for routine or emergency purposes (dental exam).
- ◆ X-rays.

##### Limitations

- ◆ Comprehensive, or detailed and extensive oral evaluation is covered once in the patient’s lifetime by the same Dentist. Subsequent comprehensive or detailed and extensive oral evaluations from the same Dentist are paid as a periodic oral evaluation.
- ◆ Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited problem-focused evaluations.
- ◆ Limited problem-focused evaluations are covered twice in a benefit period.
- ◆ Bitewing x-rays are covered once in a benefit period.
- ◆ A complete series or panoramic x-ray is covered once in a five-year period from the date of service.
  - ◇ Any number or combination of x-rays, billed for the same date of service, where the combined fees are equal to or exceed the allowed fee for a complete series, will be considered a complete series for payment and benefit limitation purposes.

##### Exclusions

- ◆ Consultations – diagnostic services provided by a Dentist other than the requesting Dentist.
- ◆ Study models.
- ◆ Diagnostic services and x-rays related to temporomandibular joints (jaw joints) are not a Class I paid Covered Dental Benefit.

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#### Class I Preventive

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##### Covered Dental Benefits

- ◆ Prophylaxis (cleaning).
- ◆ Periodontal maintenance.
- ◆ Topical application of fluoride including fluoridated varnishes.

- ◆ Sealants.
- ◆ Space maintainers.
- ◆ Preventive resin restoration.

#### Limitations

- ◆ Any combination of prophylaxis (cleaning) and periodontal maintenance is covered twice in a benefit period.
  - ◇ Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- ◆ For any combination of adult prophylaxis (cleaning) and periodontal maintenance, third and fourth occurrences may be covered if your gums have Pocket depth readings of 5mm or greater.\*
- ◆ Topical application of fluoride is limited to two covered procedures in a benefit period.
- ◆ The application of a sealant is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
  - ◇ Benefit coverage for application of sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
- ◆ Space maintainers are covered once in a patient’s lifetime through age 13 for the same quadrant.
- ◆ The application of a preventive resin restoration is a Covered Dental Benefit once in a two-year period per tooth from the date of service.
  - ◇ Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
  - ◇ The application of a preventive resin restoration is not a Covered Dental Benefit for two years after a sealant or preventive resin restoration on the same tooth.

\*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the “Confirmation of Treatment and Cost” section for additional information.

#### Exclusions

- ◆ Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits).

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### Class I Periodontics

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#### Covered Dental Benefits

- ◆ Prescription-strength fluoride toothpaste.
- ◆ Prescription-strength antimicrobial rinses.

#### Limitations

- ◆ Prescription-strength fluoride toothpaste and antimicrobial rinse are Covered Dental Benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- ◆ Proof of a periodontal procedure must accompany the claim or the patient’s history with DDWA must show a periodontal procedure within the previous 180 days.
- ◆ Prescription-strength antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- ◆ Prescription-strength antimicrobial rinse is available during pregnancy without any periodontal procedure.

## Class II Benefits

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### Class II Sedation

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#### Covered Dental Benefits

- ◆ General anesthesia.
- ◆ Intravenous moderate sedation.

#### Limitations

- ◆ General anesthesia is a Covered Dental Benefit only in conjunction with certain covered oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II and III Covered Dental Benefits.\*
- ◆ Intravenous moderate sedation is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA.\*
- ◆ Sedation, which is either general anesthesia or intravenous moderate sedation, is a Covered Dental Benefit only once per day.

\*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.

#### Exclusions

- ◆ General anesthesia or intravenous moderate sedation for routine post-operative procedures is not a paid Covered Dental Benefit except as described above for children through the age of six or a physically or developmentally disabled person.

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### Class II Palliative Treatment

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#### Covered Dental Benefits

- ◆ Palliative treatment for pain.

#### Limitations

- ◆ Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

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### Class II Restorative

---

#### Covered Dental Benefits

- ◆ Restorations (fillings).
- ◆ Stainless steel crowns or prefabricated crowns.

#### Limitations

- ◆ Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
- ◆ Restorations are covered for the following reasons:

- ◇ Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).
- ◇ Fracture resulting in significant loss of tooth structure (missing cusp).
- ◇ Fracture resulting in significant damage to an existing restoration.
- ◆ If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspid), it will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- ◆ Stainless steel crowns or prefabricated crowns are covered once in a two-year period from the date of service.

#### **Exclusions**

- ◆ Overhang removal.
- ◆ Copings.
- ◆ Re-contouring or polishing of a restoration.
- ◆ Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion.

#### **Please also see:**

- ◆ Refer to “Class III Restorative” for more information regarding coverage for crowns (other than stainless steel), inlays, veneers or onlays.

### **Class II Oral Surgery**

#### **Covered Dental Benefits**

- ◆ Removal of teeth.
- ◆ Preparation of the mouth for insertion of dentures.
- ◆ Treatment of pathological conditions and traumatic injuries of the mouth.

#### **Exclusions**

- ◆ Bone replacement graft for ridge preservation.
- ◆ Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
- ◆ Orthognathic surgery or treatment.
- ◆ Tooth transplants.
- ◆ Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

#### **Please also see:**

- ◆ “Class II Sedation” section for additional information.

### **Class II Periodontics**

#### **Covered Dental Benefits**

- ◆ Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.
- ◆ Periodontal scaling/root planing.
- ◆ Periodontal surgery.
- ◆ Limited adjustments to occlusion (eight teeth or fewer).
- ◆ Localized delivery of antimicrobial agents.\*
- ◆ Gingivectomy.

## Limitations

- ◆ Periodontal scaling/root planing is covered once per quadrant in a 36-month period from the date of service.
- ◆ Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- ◆ Periodontal surgery (per site) is covered once in a three-year period from the date of service.
- ◆ Soft tissue grafts (per site) are covered once in a three-year period from the date of service.
- ◆ Localized delivery of antimicrobial agents is a Covered Dental Benefit under certain conditions of oral health, such as periodontal Pocket depth readings of 5mm or greater.\*
  - ◇ When covered, localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
  - ◇ When covered, localized delivery of antimicrobial agents must be preceded by scaling and root planing done a minimum of six weeks and a maximum of six months prior to treatment, or the patient must have been in active supportive periodontal therapy.

\*Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.

## Please also see:

- ◆ "Class I Preventive" section for prophylaxis (cleaning) benefits.
- ◆ "Class II Sedation" section for additional information.
- ◆ "Class III Periodontics" section for complete occlusal equilibration or occlusal-guard.

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## Class II Endodontics

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### Covered Dental Benefits

- ◆ Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy, and apicoectomy.

### Limitations

- ◆ Re-treatment of the same tooth is allowed only when performed by a Dentist other than the Dentist who performed the original treatment and only if the re-treatment is performed in a dental office other than the office where the original treatment was performed.
- ◆ Re-treatment of the same tooth is not a paid Covered Dental Benefit when performed by the same Dentist or in the same dental office where the original treatment was performed, within two years of the previous root canal treatment.

### Exclusions

- ◆ Bleaching of teeth.

## Please also see:

- ◆ "Class II Sedation" section for additional information.

## Class III Benefits

*There is a six-month waiting period for all Class III Benefits.*

---

### Class III Periodontics

---

These benefits are available for patients with periodontal Pocket depth readings of 5mm or greater only, as determined by your Dentist. It is strongly recommended that prior to treatment you have your Dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

#### Covered Dental Benefits

- ◆ Occlusal-guard (nightguard).
- ◆ Repair and relines of occlusal-guard.
- ◆ Complete occlusal equilibration.

#### Limitations

- ◆ Occlusal-guard is covered once in a three-year period from the date of service.
- ◆ Repair and relines done more than six months after the date of initial placement are covered.
- ◆ Complete occlusal equilibration is covered once in a lifetime.

---

### Class III Restorative

---

#### Covered Dental Benefits

- ◆ Crowns, veneers, and onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- ◆ Crown buildups.
- ◆ Post and core on endodontically-treated teeth.
- ◆ Implant-supported crown.

#### Limitations

- ◆ A crown, veneer, or onlay on the same tooth is covered once in a seven-year period from the seat date.
- ◆ An implant-supported crown on the same tooth is covered once in a seven-year period from the original seat date of a previous crown on the same tooth.
- ◆ An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the Enrolled Person, once in a two-year period from the seat date.
- ◆ Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- ◆ A crown buildup is covered for a non-endodontically treated posterior (back) tooth only when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
- ◆ A crown buildup is covered for an endodontically or a non-endodontically treated anterior (front) tooth only when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
- ◆ A crown buildup is covered once in a seven-year period on the same tooth from the date of service.
- ◆ A post and core is covered once in a seven-year period on the same tooth from the date of service.

- ◆ Crown buildups or post and cores are not a paid Covered Dental Benefit within two years of a restoration on the same tooth from the date of service.
- ◆ A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid Covered Dental Benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- ◆ Ceramic substrate/porcelain or cast metal crowns and onlays are not a paid Covered Dental Benefit for children under 12 years of age.

#### Exclusions

- ◆ Copings.
- ◆ A core buildup is not billable with placement of an onlay, 3/4 crown, or veneer.
- ◆ A crown or onlay is not a paid Covered Dental Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- ◆ A crown or onlay placed because of weakened cusps or existing large restorations.

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### Class III Prosthodontics

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#### Covered Dental Benefits

- ◆ Dentures.
- ◆ Fixed partial dentures (fixed bridges).
- ◆ Inlays when used as a retainer for a fixed partial denture (fixed bridge).
- ◆ Removable partial dentures.
- ◆ Adjustment or repair of an existing prosthetic appliance.
- ◆ Surgical placement or removal of implants or attachments to implants.

#### Limitations

- ◆ Replacement of an existing fixed or removable partial denture is covered once every seven years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- ◆ Fixed prosthodontics for children less than 16 years of age are not a paid Covered Dental Benefit.
- ◆ Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge), and removable partial dentures shall be paid upon the seat/delivery date.
- ◆ Implants and superstructures are covered once every seven years.
- ◆ **Temporary Denture** - DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
  - ◇ Stayplate dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth.
- ◆ **Full and immediate dentures** – DDWA will allow the cost of a full or immediate denture toward the cost of an elective procedure such as an overdenture, a personalized restoration, or a specialized treatment.\*
- ◆ **Denture adjustments and relines** - Denture adjustments and relines done more than six months after the initial placement are covered two times in a 12-month period. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

#### Exclusions

- ◆ Crowns in conjunction with overdentures.

- ◆ Duplicate dentures.
- ◆ Personalized dentures.
- ◆ Copings.
- ◆ Maintenance or cleaning of a prosthetic appliance.
- ◆ Root canals in conjunction with overdentures.

\*Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your Dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the “Confirmation of Treatment and Cost” section for additional information.

## **Other Benefits**

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### **Accidental Injury**

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II, and Class III Covered Dental Benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused Plan Maximum. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage is available during the benefit period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

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### **General Exclusions**

This Plan does not cover every part of the dental care you may need. The benefits under this plan are subject to limitations listed above which affect the benefits you receive or how often some procedures will be covered. Additionally, there are exclusions to the type of services covered. These limitations and exclusions are detailed with the specific benefits listed above and in this General Exclusion section. These limitations and exclusions warrant careful reading.

These items are not paid Covered Dental Benefits under this Plan.

- 1) Dentistry for cosmetic reasons.
- 2) Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
- 3) Services for injuries or conditions that are compensable under Worker’s Compensation or Employers’ Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- 4) Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
- 5) Experimental services or supplies.
  - a) This includes:
    - i) Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
      - (1) The services are in general use in the dental community in the state of Washington;
      - (2) The services are under continued scientific testing and research;
      - (3) The services show a demonstrable benefit for a particular dental condition; and
      - (4) They are proven to be safe and effective.
    - b) Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.

- c) Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such an appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.
  - d) Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review.
- 6) Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
  - 7) Prescription drugs.
  - 8) Laboratory tests and laboratory exams.
  - 9) Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.
  - 10) Charges for missed appointments.
  - 11) Behavior management.
  - 12) Completing claim forms.
  - 13) Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), this does not include Occlusal-guard, see "Class III Periodontics" for benefit information.
  - 14) Orthodontic services or supplies.
  - 15) TMJ services or supplies.
  - 16) This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

DDWA shall determine whether services are Covered Dental Benefits in accordance with a standard dental practice and the Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this benefit booklet and may seek judicial review of any denial of coverage of benefits.

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### **Necessary vs. Not Covered Treatment**

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Your Dentist may recommend a treatment plan that includes services which may not be covered by this Plan. DDWA does not specify which treatment should be performed, only which treatment will be paid for under your Plan. While a treatment may be appropriate for managing a specific condition of oral health, it must still meet the provisions of the dental Plan in order to be a paid Covered Dental Benefit. Prior to treatment, you and your Dentist should discuss which services may not be covered as well as any fees that are your responsibility. For further information see the "Confirmation of Treatment and Cost" section.

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### **Confirmation of Treatment and Cost**

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A Confirmation of Treatment and Cost, also known as a predetermination of benefits, is a request made by your Dentist to DDWA to determine your benefits for a particular service. This Confirmation of Treatment and Cost will provide you and your Dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A Confirmation of Treatment and Cost is not an authorization for services but a notification of Covered Dental Benefits available at the time the Confirmation of Treatment and Cost is made and is not a guarantee of payment (please refer to the "Initial Benefit Determination" section regarding claims requirements).

A standard Confirmation of Treatment and Cost is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete, DDWA will notify you and your Dentist in writing that additional information is required in order to process the Confirmation of Treatment and Cost. Once the additional information is available your Dentist should submit a new request for a Confirmation of Treatment and Cost to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the Confirmation of Treatment and Cost is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

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**Urgent Confirmation of Treatment and Cost Requests**

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Should a Confirmation of Treatment and Cost request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or Dentist who has knowledge of the medical condition, DDWA will review the request within 72 hours from the receipt of the request and all supporting documentation. When practical, DDWA may provide notice of the determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a Confirmation of Treatment and Cost in an emergency situation subject to the contract provisions.

## Section C – Choosing a Dentist

Your Provider Network is: Delta Dental PPO Network.

You may select any licensed Dentist to provide services under this Plan; however, if you choose a Dentist outside of the Delta Dental PPO Network, your costs may be higher than if you were to choose a Delta Dental PPO Dentist. Dentists that do not participate in the Delta Dental PPO Network have not contracted with DDWA to charge our established PPO fees for covered services. As a result, your choice of Dentists could substantially impact your out-of-pocket costs.

Once you choose a Dentist, tell them that you are covered by a DDWA dental plan and provide them the name and number of your group and your member identification number. Your group information can be found on the identification card document provided to you at enrollment, or printed from [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com). You may also obtain your group information and your member identification number by calling our Customer Service Department at 800-554-1907 or through our website at [www.DeltaDentalWa.com](http://www.DeltaDentalWa.com).

Delta Dental of Washington uses randomly selected identification numbers or universal identifiers to ensure the privacy of your information and to help protect against identity theft.

Please note that ID cards are not required to see your Dentist, but are provided for your convenience.

### Delta Dental Participating Dentists

Dentists who have agreed to provide treatment to patients covered by a DDWA plan are called 'Participating' Dentists. For your Plan, Participating Dentists may be either Delta Dental Premier Dentists or Delta Dental PPO Dentists. You can find the most current listing of Participating Dentists by going online to the Delta Dental of Washington website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com). You may also call us at 800-554-1907.

#### Delta Dental Premier Dentists

Premier Dentists have agreed to provide services for their filed fee under our standard agreement.

#### Delta Dental PPO Dentists

Our PPO Dentists have agreed to provide services at a fee lower than their original filed fee. Because of this, selecting a PPO Dentist may be a more cost effective option for you.

If you select a Delta Dental Participating Dentist they will complete and submit claim forms, and receive payment directly from DDWA on your behalf. Payment will be based on the pre-approved fees your Dentist has filed with their local Delta Dental Plan. You will not be charged more than the Participating Dentist's approved fee. You will be responsible only for stated coinsurances, deductibles, any amount over the Plan Maximum and for any elective care you choose to receive outside the Covered Dental Benefits.

### Non-Participating Dentists

If you select a Dentist who is not a Delta Dental Participating Dentist, you are responsible for ensuring either you or your Dentist completes and submits a claim form. We accept any American Dental Association-approved claim form that you or your Dentist may provide. You can also download claim forms from our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com) or obtain a form by calling us at 800-554-1907.

Payment for services performed by a Non-Participating Dentist will be based on their actual charges or the maximum allowable fees for Non-Participating Dentists in the state in which the services are performed, whichever is less. You will be responsible for paying any balance remaining to the Dentist. Please be aware that DDWA has no control over Non-Participating Dentist's charges or billing practices.

## Section D – Eligibility and Termination

### Employee Eligibility and Enrollment

An Eligible Employee is an employee who meets the qualifications for eligibility established by Group.

Eligible Employees become Enrolled Employees once they have fully completed the enrollment process and DDWA has received the employer contributions for their enrollment.

New employees are eligible to enroll in this Plan on the first day of the month after satisfying any waiting period established by the Group.

You must complete the enrollment process in order to receive benefits.

### Employee Termination

Eligibility and Coverage terminates at the end of the month in which you cease to be an employee, or at the end of the month for which timely payment of monthly Premiums was made by Group on your behalf to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

In the event of a suspension or termination of compensation, directly or indirectly as a result of a strike, lockout, or other labor dispute, an Enrolled Employee may continue coverage by paying the applicable Premium directly to the employer for a period not to exceed six months. Payments of premiums must be made when due, or DDWA may terminate the coverage.

The benefits under your DDWA dental Plan may be continued provided you are eligible for Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family Medical Leave Act (PFML) and you are on a leave of absence that meets the appropriate criteria. For further information, contact your employer.

### Dependent Eligibility and Enrollment

Eligible Dependents are your spouse or domestic partner, and children of yours, your spouse, or your domestic partner, from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. A dependent child's spouse and/or child(ren) are not eligible for coverage under this Plan.

Non-registered domestic partnership is a relationship whereby two people:

- 1) Share the same regular and permanent residence;
- 2) Have a close personal committed relationship;
- 3) Are jointly responsible for "basic living expenses" such as food, shelter and similar expenses;
- 4) Are not married to anyone;
- 5) Are each 18 years of age or older;
- 6) Are not related by blood closer than would bar marriage in their state of residence;
- 7) Were mentally competent to consent to contract when the domestic partnership began; and
- 8) Are each other's sole domestic partner and are responsible for each other's common welfare.

Eligible Dependents may not enroll in this Plan unless the employee is an Enrolled Employee.

A new family member, with the exception of newborns, adopted and foster children, should be enrolled on the first day of the month following the date they qualify as an Eligible Dependent.

A newborn shall be covered from and after the moment of birth, and an adopted child or child placed in anticipation of adoption shall be covered from the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. A foster child is covered from the time of placement.

A child will be considered an Eligible Dependent as an adopted child if one of the following conditions are met: 1) the child has been placed with the eligible Enrolled Employee for the purpose of adoption under the laws of the state in

which the employee resides; or 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption.

When additional premium is required for a newborn or adopted child or child placed in anticipation of adoption, enrollment must be received by DDWA within the timeframe listed under “Marriage, Birth and Adoption” section, which is no less than 60 days from the date of the qualifying event.

When additional premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Enrolled employees who choose not to enroll an Eligible Dependent during the initial enrollment period of the dental Plan may enroll the Eligible Dependent only during an Open Enrollment, except under special enrollment. See the “Special Enrollment” section for more information. An enrolled dependent is an Eligible Dependent that has completed the enrollment process.

## **Dependent Termination**

Enrolled Dependent coverage terminates at the end of the month in which the enrolled employee’s coverage terminates, or when the dependent ceases to be eligible, whichever occurs first.

Unless otherwise indicated, an Enrolled Dependent shall cease to be enrolled in this Plan on the last day of the month of the Enrolled Employee’s employment, or when the person no longer meets the definition of an Eligible Dependent, or the end of the calendar month for which Group has made timely payment of the monthly Premiums on behalf of the Enrolled Employee to DDWA, or upon termination of Group’s Contract with DDWA, whichever occur first.

A Dependent may be enrolled or terminated from coverage or reinstate coverage under this Plan during Open Enrollment or during a Special Enrollment Period following a qualifying event as defined in the “Special Enrollment” section.

## **Other Dependent Eligibility Topics**

Coverage for an Enrolled Dependent child who attains the limiting age while covered under this Plan will not be terminated if the child is and continues to be both 1) incapable of self-sustaining employment by reasons of developmental disability (attributable to intellectual disability or related conditions which include cerebral palsy, epilepsy, autism, or another neurological condition which is closely related to intellectual disability or which requires treatment similar to that required for intellectually disabled individuals) or physical disability; and 2) chiefly dependent upon the Enrolled Person for support and maintenance. Continued coverage requires that proof of incapacity and dependency be furnished to DDWA within 31 days of the dependent’s attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the Plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. If the parent is not enrolled in the Plan, the parent must enroll for coverage for both the parent and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

## **Special Enrollment Periods**

Enrollment or termination of you or your Eligible Dependent is allowed at Open Enrollment times, and during Special Enrollment Periods, which are triggered by the following situations:

## Loss of Other Coverage

If you and/or your Eligible Dependents involuntarily lose coverage or are no longer eligible under another dental plan, you may apply for coverage or make changes under this Plan if the following applies:

- ◆ You declined enrollment in this Plan.
- ◆ You lose eligibility in another health Plan or your coverage is terminated due to the following:
  - ◇ Legal separation or divorce
  - ◇ Cessation of dependent status
  - ◇ Death of Employee
  - ◇ Termination of employment or employer contributions
  - ◇ Reduction in hours
  - ◇ Loss of individual or group market coverage due to moving away from the Plan area or termination of benefit plan
  - ◇ Exhaustion of COBRA coverage
- ◆ The enrollment process must be completed within 30 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

If these conditions are not met, you must wait until the next Open Enrollment Period, or the occurrence of another valid qualifying election event, to apply for coverage.

## Marriage, Birth or Adoption

If you declined enrollment in this Plan, you may apply for coverage for yourself and your Eligible Dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support or upon placement of a child(ren) in anticipation of adoption.

- ◆ Marriage or Domestic Partner Registration – The enrollment process must be completed within the timeframe established by the Group. If enrollment and payment are not completed within the timeframe established, any changes to enrollment can be made during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

DDWA considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefit booklet will be considered as gender neutral and applicable to individuals in domestic partnerships. DDWA and the group will follow all applicable state and federal requirements, including any applicable regulations.
- ◆ Birth – A newborn shall be covered from and after the moment of birth. The enrollment process must be completed within 60 days of the date of birth. If additional Premium for coverage is required and enrollment and payment is completed after 60 days, the enrollment becomes effective on the first day of the month in which enrollment occurs. Enrollment may be completed at any time up to the fourth birthday. Enrollment after the fourth birthday must be coincident with an Open Enrollment period or upon the occurrence of another valid qualifying election change event.
- ◆ Adoption – The enrollment process must be completed within 60 days of the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. If an additional Premium for coverage is required and enrollment and payment is not completed within the 60 days, any changes to enrollment can be made during the next Open Enrollment or upon the occurrence of another valid qualifying election change event.

### **Uniformed Services Employment & Re-Employment Rights Act (USERRA)**

Enrolled Employees who join a branch of military service have the right to continue dental coverage as established by Group by paying the monthly Premiums, even if they are employed by groups that are too small to comply with COBRA. For further information on your rights under this act, please contact your legal counsel.

### **Family and Medical Leave Act (FMLA) and Paid Family Medical Leave (PFML)**

The benefits for an enrolled member under this DDWA dental Plan may be continued provided the employee is eligible for the Federal Family and Medical Leave Act (FMLA) or Washington State's Paid Family Medical Leave Act (PFML) and is on a leave of absence that meets the appropriate criteria. For further information, contact your employer.

### **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

Federal law requires that should certain qualifying events occur which would have previously terminated coverage, coverage may continue for a period of time on a self-pay basis.

When you terminate for reasons other than gross misconduct, you may continue your dental benefits for up to 18 months by self-paying the required Premium. This option to continue dental benefits terminates if you become eligible for coverage under another group dental plan.

If a dependent no longer meets the eligibility requirements due to the death, divorce, or dissolution of domestic partnership of the employee, or does not meet the age requirement for children, coverage may continue up to three years by self-paying the required Premium. This option to continue dental benefits terminates if the dependent becomes eligible for coverage under another group dental plan.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for eligible persons.

## Section E – Claim Review

### Claim Forms

American Dental Association-approved claim forms may be obtained from your Dentist. You may also download claim forms from our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com) or call us at 800-554-1907 to have forms sent to you.

DDWA is not obligated to pay for treatment performed for which claim forms are submitted for payment more than six months after the date of such treatment.

### Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to DDWA for payment modification or denial of payment. In accordance with regulatory requirements, DDWA processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, we will send you an Explanation of Benefits (EOB) that will include the following information:

- ◆ The specific reason for the denial or modification
- ◆ Reference to the specific plan provision on which the determination was based
- ◆ Your appeal rights should you wish to dispute the original determination

### Appeals of Denied Claims

#### How to contact us

We will accept notice of an Urgent Care, Grievance, or Appeal if made by you, your covered dependent, or an authorized representative of you or your covered dependent by contacting us at the telephone number below or in writing us at the following address: Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983, or by email at [memberappeals@deltadentalwa.com](mailto:memberappeals@deltadentalwa.com). You may include any written comments, documents or other information that you believe supports your claim. For more information please call 800-554-1907.

#### Authorized Representative

You may authorize another person to represent you or your dependent and receive communications from DDWA regarding you or your dependent's specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed authorized representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

#### Informal Review

If your claim for dental benefits has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to initiate an appeal. Your first step in the appeal process is to request an informal review of the decision. Either you, or your authorized representative (see the "Authorized Representative" section), must submit your request for a review within 180 days from the date of the adverse benefit determination (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and must include the following information:

- ◆ Your name, the patient's name (if different) and ID number
- ◆ The claim number (from your Explanation of Benefits)
- ◆ The name of the Dentist

DDWA will review your request and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

### **Formal Review**

If you are dissatisfied with the outcome of the informal review, you may request a formal appeal. Your formal appeal will be reviewed by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original decision or the previous review.

Your request for a review by the Appeals Committee must be made within 90 days of the date of the letter notifying you of the informal review decision. Your request should include the information submitted with your informal review request plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim within 30 days of receiving your request. Upon completion of their review the Appeals Committee will send you written notification of their decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulations.

### **How to Report Suspicion of Fraud**

If you suspect a dental provider, an insurance producer or an individual might be committing insurance fraud, please contact DDWA at 800-554-1907. You may also want to alert any of the appropriate law enforcement authorities including:

- ◆ The National Insurance Crime Bureau (NICB). You can reach the NICB at 800-835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- ◆ The Office of the Insurance Commissioner (OIC). You can reach the OIC at 360-725-7263 or go to [www.insurance.wa.gov](http://www.insurance.wa.gov) for more information.

### **Your Rights and Responsibilities**

We view our benefit packages as a partnership between DDWA, our subscribers, and our Participating Dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

#### **You Have The Right To:**

- ◆ Seek care from any licensed Dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental Participating Dentist or Non-Participating Dentist), but you can receive care from any Dentist you choose.
- ◆ Participate in decisions about your oral health care.
- ◆ Be informed about the oral health options available to you and your family.
- ◆ Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- ◆ Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care Dentist makes a specific referral for specialty care.

- ◆ Contact the DDWA Customer Service Department during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com).
- ◆ Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage and have these issues resolved in a timely, professional and fair manner.
- ◆ Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- ◆ Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

**To Receive the Best Oral Health Care Possible, It Is Your Responsibility To:**

- ◆ Know your benefit coverage and how it works.
- ◆ Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24-hour notice for appointment cancellations before they will waive service charges.
- ◆ Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- ◆ Give accurate and complete information about your health status and history and the health status and history of your family to all healthcare providers when necessary.
- ◆ Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- ◆ Follow instructions given by your Dentist or their staff concerning daily oral health improvement or post service care.
- ◆ Send requested documentation to DDWA to assist with the processing of claims, Confirmation of Treatment and Costs, or appeals.
- ◆ If applicable, pay the dental office any appropriate coinsurance or deductible amounts at time of visit.
- ◆ Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- ◆ Inform your Dentist and your employer promptly of any change to your, or a family member's address, telephone, or family status.

**Health Insurance Portability and Accountability Act (HIPAA)**

Delta Dental of Washington is committed to protecting the privacy of your dental health information in compliance with the Health Insurance Portability and Accountability Act. You can get our Notice of Privacy Practices by visiting [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com), or by calling DDWA at 800-554-1907.

**Conversion Option**

If your dental coverage stops because your employment or eligibility ends, the group policy ends, or there is an extended strike, lockout or labor dispute, you may apply directly to DDWA to convert your coverage to a Delta Dental Individual and Family plan. You must apply within 31 days of termination of your group coverage or 31 days after you receive notice of termination of coverage, whichever is later. The benefits and premium costs of a Delta Dental Individual and Family plan may be different from those available under your current plan. You may learn about our Individual and Family plans and apply for coverage online at [www.DeltaDentalCoversMe.com](http://www.DeltaDentalCoversMe.com) or by calling 888-899-3734.

**Extension of Benefits**

In the event a person ceases to be eligible for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. An exception will be made for the completion of procedures requiring multiple visits that were started while coverage was in effect, are completed within 21 days of the termination date, and are otherwise benefits under the terms of this Plan.

## Coordination of Benefits

Coordination of this Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

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

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

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

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plans* or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.
- *Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state *Plan* under Medicaid; A governmental *plan*, which, by law, provides benefits that are in excess of those of any private insurance *Plan* or other nongovernmental *plan*; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plans*, unless permitted by law.

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has 2 parts and COB rules apply only to one of the 2, each of the parts is treated as a separate *Plan*.

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

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan's* benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

**“Allowable Expense”** except as outlined below, means any health care expense including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering you. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary Plan would have paid if it was the primary plan. In no event will DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare’s allowable amount is the allowable expense.

An expense or a portion of an expense that is not covered by any of the *plans* is not an allowable expense. The following are examples of expenses that are not *Allowable Expenses*:

- If you are covered by 2 or more Plans that compute their benefit payments on the basis of a maximum allowable amount, relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by 2 or more *Plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of this plan’s negotiated fee is not an *Allowable Expense*.

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

**“Custodial Parent”** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

**Order of Benefit Determination Rules:** When you are covered by 2 or more *Plans*, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plans* state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

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

**“Non-Dependent or Dependent”** The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the 2 *Plans* is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

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

- 1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
  - a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
  - b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
- 2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - a) If a court decree states that one of the parents is responsible for the *Dependent* child’s dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
  - b) If a court decree states one parent is to assume primary financial responsibility for the *Dependent* child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
  - c) If a court decree states that both parents are responsible for the *Dependent* child’s dental expenses or dental coverage, the provisions of point 1) above (for *dependent* child(ren) whose parents are married or are living together) determine the order of benefits;
  - d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the *Dependent* child, the provisions of point 1) above (for *dependent* child(ren) whose parents are married or are living together) determine the order of benefits; or
  - e) If there is no court decree allocating responsibility for the *Dependent* child’s dental expenses or dental coverage, the order of benefits for the child is as follows:
    - I. The *Plan* covering the *Custodial Parent*, first;
    - II. The *Plan* covering the spouse of the *Custodial Parent*, second;
    - III. The *Plan* covering the *noncustodial Parent*, third; and then
    - IV. The *Plan* covering the spouse of the *noncustodial Parent*, last
- 3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of points 1) or 2) above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

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

**“COBRA or State Continuation Coverage”:** If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

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

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

**Effect on the Benefits of This Plan:** When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plans* during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. *Total Allowable Expense* is the *Allowable Expense* of the *Primary Plan* or the *Secondary Plan up to this plan’s allowable expense*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

**How We Pay Claims When We Are Secondary:** When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the *plan*.

- If there is a difference between the amounts the *plans* allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plans*.

- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plans* for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each Plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan(s)* for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

**Right to Receive and Release Needed Information:** Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plans*. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plans* covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

**Facility of Payment:** If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

**Right of Recovery:** The Company has the right to recover excess payment whenever it has paid *Allowable Expenses* in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plans*.

**Notice to Covered Persons** If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plans* to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

**CAUTION:** All health *Plans* have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan's* claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one *Plan* you should promptly report to your providers and *Plans* any changes in your coverage.

## Subrogation

If we pay benefits under this policy, and you are paid by someone else for the same procedures we pay for, we have the right to recover what we paid from the excess received by you, after full compensation for your loss is received. Any legal fees for recovery will be pro-rated between the parties based on the percentage of the recovery received. You have to sign and deliver to us any documents relating to the recovery that we reasonably request.

## Section F - Resources

### Frequently Asked Questions about Your Dental Benefits

#### What is a Delta Dental “Participating Dentist”?

A Delta Dental Participating Dentist is a Dentist who has signed an agreement with Delta Dental stipulating that he or she will provide dental treatment to subscribers and their dependents who are covered by DDWA’s group dental care plans. Delta Dental Participating Dentists submit claims directly to DDWA for their patients.

#### Can I choose my own Dentist?

See the “Choosing a Dentist” section for more information.

#### How can I obtain a list of Delta Dental Participating Dentists?

You can obtain a current list of Delta Dental Participating Dentists by going to our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com). You may also call us at 800-554-1907.

#### How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your Dentist. You can also obtain a copy of the approved claim form from our website at [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com) or by calling our Customer Service Number at 800-554-1907. Note: If your Dentist is a Delta Dental Participating Dentist, he or she will complete and submit claim forms for you.

#### What is the mailing address for DDWA claim forms?

If you see a Delta Dental Participating Dentist, the dental office will submit your claims for you. If your Dentist is not a Participating Dentist, it will be up to you to ensure that the dental office submits your claims to Delta Dental of Washington at P.O. Box 75983, Seattle, WA 98175-0983.

#### Who do I call if I have questions about my dental plan?

If you have questions about your dental benefits, call DDWA’s Customer Service Department at 800-554-1907. Questions can also be addressed via email at [CSservice@DeltaDentalWA.com](mailto:CSservice@DeltaDentalWA.com).

#### Does DDWA cover tooth colored fillings on my back teeth?

It is your group’s choice to cover posterior composite fillings (tooth colored fillings on your back teeth), or only allow posterior amalgam fillings (silver fillings on your back teeth). Please see the “Benefits Covered by Your Plan” section to determine which election your Group has made. You may also log on to the “MySmile® Personal Benefits Center” on our website, [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com), or call us at 800-554-1907 for assistance in determining whether or not your Plan covers posterior composite fillings.

#### Do I have to get an “estimate” before having dental treatment done?

You are not required to get an estimate before having treatment, but you may wish to do so. You may ask your Dentist to complete and submit a request for an estimate, called a Confirmation of Treatment and Cost. The estimate will provide you with estimated cost for your procedure, but is not a guarantee of payment.

#### Who is Delta Dental?

Delta Dental Plans Association is a national organization made up of local, nonprofit Delta Dental plans that provide dental benefits coverage. DDWA is a member of the Delta Dental Plans Association.

## **Glossary**

### **Alveolar**

Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

### **Amalgam**

A mostly silver filling often used to restore decayed teeth.

### **Apicoectomy**

Surgery on the root of the tooth.

### **Appeal**

An oral or written communication by a subscriber or their authorized representative requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage authorization, or provision of health care services or benefits.

### **Bitewing X-ray**

An X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gum line, as well as a portion of the roots and supporting structures of these teeth.

### **Bridge**

Also known as a fixed partial denture. See "Fixed Partial Denture".

### **Certificate of Coverage**

The benefits booklet which describes in summary form the essential features of the contract coverage, and to or for whom the benefits hereunder are payable.

### **Caries**

Decay. A disease process initiated by bacterially produced acids on the tooth surface.

### **Complaint**

An oral or written report by a subscriber or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

### **Comprehensive Oral Evaluation**

Typically used by a general Dentist and/or specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

### **Contract**

This agreement between DDWA and Group. The Contract constitutes the entire Contract between the parties and supersedes any prior agreement, understanding or negotiation between the parties.

### **Coping**

A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. The purpose of a coping is to allow the removal and modification of the bridge without requiring a major remake of the bridgework, if the tooth is lost.

### **Covered Dental Benefits**

Those dental services that are covered under this Contract, subject to the limitations set forth in "Benefits Covered by Your Plan" section.

### **Crown**

A restoration that replaces the entire surface of the visible portion of tooth.

### **DDWA**

Delta Dental of Washington, a nonprofit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

### **Delivery Date**

The date a prosthetic appliance is permanently cemented into place.

**Delta Dental**

Delta Dental Plans Association, which is a nationwide nonprofit organization of health care service plans, which offers a range of group dental benefit plans.

**Delta Dental Participating Dentist**

A licensed Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written agreement between Delta Dental and such Dentist, which includes looking solely to Delta Dental for payment for covered services.

**Delta Dental PPO Dentist**

A Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental PPO agreement, which includes looking solely to Delta Dental for payment for covered services.

**Dentist**

A licensed Dentist legally authorized to practice dentistry at the time and in the place services are performed. This Plan provides for covered services only if those services are performed by or under direction of a licensed Dentist or other Licensed Professional operating within the scope of their license.

**Denture**

A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

**Eligibility Date**

The date on which an Eligible Person becomes eligible to enroll in the Plan.

**Eligible Dependent**

Any dependent of an Eligible Employee who meets the conditions of eligibility set forth in "Dependent Eligibility and Enrollment."

**Eligible Employee**

Any employee who meets the conditions of eligibility set forth in "Employee Eligibility and Enrollment."

**Eligible Person**

An Eligible Employee or an Eligible Dependent.

**Emergency Dental Condition**

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

**Emergency Examination**

Also known as a "limited oral evaluation – problem focused." Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

**Endodontics**

The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

**Enrolled Dependent, Enrolled Employee, Enrolled Person**

Any Eligible Dependent, Eligible Employee or Eligible Person, as applicable, who has completed the enrollment process and for whom Group has submitted the monthly Premium to DDWA.

**Exclusions**

Those dental services that are not contract benefits set forth in your "Benefits Covered by Your Plan" section and all other services not specifically included as a Covered Dental Benefit set forth in "Benefits Covered by Your Plan" section.

**Filed Fees**

Approved fees that participating Delta Dental Participating Dentists have agreed to accept as the total fees for the specific services performed.

**Filled Resin**

Tooth colored plastic materials that contain varying amounts of special glass like particles that add strength and wear resistance.

**Fixed Partial Denture**

A replacement for a missing tooth or teeth. The fixed partial denture consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). They are cemented (fixed) in place and therefore are not removable.

**Fluoride**

A chemical agent used to strengthen teeth to prevent cavities.

**Fluoride Varnish**

A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

**General Anesthesia**

A drug or gas that produces unconsciousness and insensibility to pain.

**Group**

The employer or entity that is contracting for the dental benefits described in this benefit booklet for its employees.

**Implant**

A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

**Inlay**

A dental filling shaped to the form of a cavity and then inserted and secured with cement.

**Intraoral X-rays Complete Series (including bitewings)**

A series of radiographs which display the tooth and coronal portions of all the teeth in the mouth.

**Intravenous (I.V.) Sedation**

A form of sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

**Licensed Professional**

An individual legally authorized to perform services as defined in his or her license. Licensed professionals include, but are not limited to, dentist, hygienist and radiology technician. Benefits under this Contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW.

**Lifetime Maximum**

The maximum amount DDWA will pay in the specified covered dental benefit class for an insured individual during the time that individual is on this Plan or any other Plan offered by this Employer.

**Limitations**

An exception or condition of coverage for a particular Covered Dental Benefit.

**Localized Delivery of Antimicrobial Agents**

Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

**Maximum Allowable Fees**

The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

**Nightguard**

See "Occlusal-guard."

**Non-Participating Dentist**

A licensed Dentist who has not agreed to render services and receive payment in accordance with the terms and conditions of a written Member Dentist Agreement between a member of the Delta Dental Plans Association and such Dentist.

**Not a paid Covered Dental Benefit**

Any dental procedure that, is covered under this Plan, however is not payable based on specific conditions, such as clinical criteria.

**Occlusal Adjustment**

Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

**Occlusal-Guard – (Nightguard)**

A removable dental appliance – sometimes called a nightguard – that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal-guard is typically used at night.

**Onlay**

A restoration of the contact surface of the tooth that covers the entire surface.

**Open Enrollment Period**

The annual period in which subscribers can select benefits plans and add or delete Eligible Dependents.

**Orthodontics**

Diagnosis, prevention, and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

**Overdenture**

A removable denture constructed over existing natural teeth or implanted studs.

**Palliative Treatment**

Services provided for emergency relief of dental pain.

**Panoramic X-ray**

An X-ray, taken from outside the mouth that shows the upper and lower teeth and the associated structures in a single picture.

**Participating Plan**

Delta Dental of Washington, and any other member of the Delta Dental Plans Association with which Delta Dental contracts to assist in administering the benefits described in this Benefits Booklet.

**Payment Level**

The applicable percentage of Maximum Allowable Fees for Covered Dental Benefits that shall be paid by DDWA as set forth in the Summary of Benefits and Reimbursement Levels sections of this Benefits Booklet.

**Periodic Oral Evaluation – (Routine Examination)**

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

**Periodontics**

The diagnosis, prevention, and treatment of diseases of gums and the bone that supports teeth.

**Plan**

The dental benefits as provided and described in this Benefits Booklet and its accompanying Contract. Any other booklet or contract that provides dental benefits and meets the definition of a "Plan" in the "Coordination of Benefits" section of the Certificate of Coverage is a Plan for the purpose of coordination of benefits.

**Pocket Depth**

An internal measurement from the top of the gum tissue to its attachment on the root of a tooth.

**Premium**

The monthly amount payable to DDWA by Group, and/or by an Enrolled Employee to Group, as designated in the Contract.

**Prophylaxis**

Cleaning and polishing of teeth.

**Prosthodontics**

The replacement of missing teeth by artificial means such as bridges and dentures.

**Pulpotomy**

The removal of nerve tissue from the crown portion of a tooth.

**Qualified Medical Child Support Order (QMCSO)**

An order issued by a court under which a member must provide medical coverage for a dependent child. QMCSO's are often issued, for example, following a divorce or legal separation.

**Resin-Based Composite**

A tooth colored filling, made of a combination of materials, used to restore teeth.

**Restorative**

Replacing portions of lost or diseased tooth structures with a filling or crown to restore proper dental function.

**Root Planing**

A procedure done to smooth roughened root surfaces.

**Sealants**

A material applied to teeth to seal surface irregularities and prevent tooth decay.

**Seat Date**

The date a crown, veneer, inlay, or onlay is permanently cemented into place on the tooth.

**Specialist**

A licensed Dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association recognized certifying board.

**Temporomandibular Joint**

The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

**Veneer**

A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention.

## Nondiscrimination and Language Assistance Services

Delta Dental of Washington complies with applicable Federal and Washington State civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Delta Dental of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

We will provide free aids and services to people with disabilities to assist in communicating effectively with DDWA staff, such as:

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

We will provide free language services to assist in communicating effectively with DDWA staff for people whose primary language is not English, such as:

- ◆ Qualified interpreters
- ◆ Information written in other languages

If you need these services, contact Delta Dental of Washington's Customer Service at: 800-554-1907. If you need translation or interpreter assistance at your dental provider's office, please contact their staff. The cost for translations and interpreter services for communication between you and your provider are not covered by DDWA.

If you believe that Delta Dental of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our Compliance/Privacy Officer who may be reached as follows: PO Box 75983 Seattle, WA 98175, Ph: 800-554-1907, TTY: 800-833-6384, Fx: 206 729-5512 or by email at: [Compliance@DeltaDentalWA.com](mailto:Compliance@DeltaDentalWA.com). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Compliance/Privacy Officer is available to help you.

You can also file a civil rights complaint with:

- ◆ The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- ◆ The Washington State Office of Insurance Commissioner, electronically through the Office of Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-compliant-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

Taglines
<p><b>Amharic</b></p> <p>እርስዎ፣ ወይም ሌላ እየረዱት ያለ ሰው፣ ስለ Delta Dental of Washington ጥያቄ ካላችሁ፣ በራሳችሁ ቋንቋ ያለምንም ክፍያ እርዳታ እና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማውራት፣ በ 800-554-1907 ይደውሉ።</p>
<p><b>Arabic</b></p> <p>إذا كانت لديك أو لدى أي شخص آخر تساعده أسئلة حول Delta Dental of Washington، فلك الحق في طلب المساعدة والمعلومات بلغتك دون أن تتحمل أي تكلفة. للتحدث إلى مترجم، يُرجى الاتصال على الرقم 800-554-1907.</p>
<p><b>Cambodian (Mon-Khmer)</b></p> <p>ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពីកម្មវិធី Delta Dental of Washington អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាការសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែសូមទូរស័ព្ទទៅលេខ 800-554-1907។</p>
<p><b>Chinese</b></p> <p>如果您或您正在帮助的人对 Delta Dental of Washington 有任何疑问，您有权免费以您的语言获得帮助和信息。要想联系翻译员，请致电 800-554-1907。</p>
<p><b>Cushite (Oromo)</b></p> <p>Ati yookaan namni ati gargaaraa jirtu waa'ee Delta Dental of Washington gaaffilee yoo qabaattan kaffaltii malee afaan keetiin gargaarsaa fi odeeffannoo argachuu ni dandeessa. Nama afaan sii hiiku dubbisuuf lakk. 800-554-1907tiin bilbili.</p>
<p><b>French</b></p> <p>Si vous, ou quelqu'un à qui vous apportez votre aide, avez des questions à propos de Delta Dental of Washington, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 800-554-1907.</p>
<p><b>German</b></p> <p>Falls Sie oder jemand, dem Sie helfen, Fragen zu Delta Dental of Washington haben, sind Sie berechtigt, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-554-1907 an.</p>
<p><b>Japanese</b></p> <p>ご本人様、またはお客様の身寄りの方でも Delta Dental of Washington についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したりすることができます。料金はかかりません。通訳とお話される場合 800-554-1907 までお電話ください。</p>
<p><b>Korean</b></p> <p>귀하 또는 귀하가 돕고 있는 누군가에게 Delta Dental of Washington 에 대한 질문이 있을 경우, 귀하는 무료로 귀하의 언어로 도움을 제공받을 권리가 있습니다. 통역사와 통화를 원하시면 800-554-1907 로 전화하십시오.</p>
<p><b>Laotian</b></p> <p>ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດໜຶ່ງທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Delta Dental of Washington, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໃດໆບໍ່ເສຍຄ່າ. ເພື່ອນົມກັບຜູ້ແປພາສາ, ໂທ 800-554-1907.</p>
<p><b>Persian (Farsi)</b></p> <p>دارد، این حق را دارید که اطلاعات مورد نیازتان را به Delta Dental of Washington اگر شما، یا شخصی که به وی کمک می کنید، سؤالی درباره ی تماس بگیرید. 800-554-1907 جهت صحبت با یک مترجم شفاهی، با شماره زبان خود و بدون هیچ هزینه ای دریافت کنید.</p>
<p><b>Punjabi</b></p> <p>ਜੇ ਤੁਹਾਡੇ ਜਾਂ ਜਿਸ ਦੀ ਤੁਸੀਂ ਸਹਾਇਤਾ ਕਰ ਰਹੇ ਹੋ ਉਸ ਦੇ, Delta Dental of Washington ਬਾਰੇ ਕੋਈ ਪ੍ਰਸ਼ਨ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਆਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 800-554-1907 'ਤੇ ਕਾਲ ਕਰੋ।</p>
<p><b>Romanian</b></p> <p>Dacă dumneavoastră sau o persoană pe care o asistați aveți întrebări despre Delta Dental of Washington, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 800-554-1907.</p>

<b>Taglines</b>
<p><b>Russian</b>  Если у Вас или у лица, которому Вы помогаете, имеются вопросы относительно Delta Dental of Washington, то Вы имеете право на получение бесплатной помощи и информации на Вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру 800-554-1907.</p>
<p><b>Serbo-Croatian</b>  Ako vi, ili osoba kojoj pomažete, imate pitanja o kompaniji Delta Dental of Washington, imate pravo da potražite besplatnu pomoć i informacije na svom jeziku. Pozovite 800-554-1907 da razgovarate s prevodiocem.</p>
<p><b>Spanish</b>  Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Washington, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-554-1907.</p>
<p><b>Sudan (Fulfulde)</b>  To onon, mala mo je on mballata, don mari emmmolji do Delta Dental of Washington, on mari jarfuye kebbugo wallende be matinolji be wolde moƕon mere. Ngam wolwugo be lornowo, ewne 800-554-1907.</p>
<p><b>Tagalog</b>  Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan tungkol sa Delta Dental of Washington, mayroon kang karapatan humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 800-554-1907.</p>
<p><b>Ukrainian</b>  Якщо у Вас або у когось, кому Ви допомагаєте, є запитання щодо Delta Dental of Washington, Ви маєте право безкоштовно отримати допомогу та інформацію Вашою мовою. Щоб поговорити з перекладачем, телефонуйте за номером 800-554-1907.</p>
<p><b>Vietnamese</b>  Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có thắc mắc về Delta Dental of Washington, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi 800-554-1907.</p>

Your smile is part of an incredible, complex system – your body. Research shows your smile’s health influences your body’s health the same way an engine effects how a car performs. Taking care of your smile now helps prevent painful, expensive problems down the road.

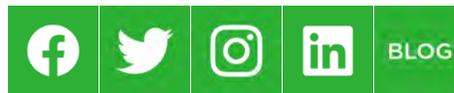
Here are our top tips for a healthy smile:

- ◆ Brush for two minutes, twice a day with fluoride toothpaste
- ◆ Floss at least once a day
- ◆ Eat a well-balanced diet
- ◆ Drink fluoridated water
- ◆ Visit your Dentist at least once a year

Remember, your smile has a great service plan – your dental coverage. It makes dental visits easy and affordable.

So, why wait? Call your Dentist and schedule your next visit today. If you’re looking for a Dentist, visit [www.DeltaDentalWA.com](http://www.DeltaDentalWA.com) to find one near you.

Follow us online for fun, helpful tips to keep your smile healthy and get the most from your dental benefits.





## Basic Life and AD&D Insurance

### BIAW Health Trust

#### How the Plan Works

Life is full of many twists and turns. LifeMap Basic Life and AD&D coverage protects your family's future, no matter what life may throw your way.

- **Who pays for the coverage?**  
Life and AD&D Insurance premiums are paid for by your employer.
- **Guarantee Issue**  
With no questions asked, you will be covered for up to \_\_\_\_\_ of Basic Life and AD&D Insurance. Minimum participation rates apply.

**LifeMapCo.com**  
**1 (800) 794-5390**

#### Benefits Summary

##### Plan Benefits

Employee Life Insurance	
Employee AD&D Insurance	

##### Guarantee Issue Amount

Employee	
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##### Plan Features

Accelerated Benefit – Life Only	A covered employee who is diagnosed as terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Conversion – Life Only	Option of converting to an individual life policy, without proof of insurability, within 31 days of termination.
Waiver of Premium – Life Only	Life coverage continued without payment of premium if you become totally disabled prior to age 60 (proof of disability required). Coverage may be continued up to age 65.

##### Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 70, your benefits will reduce to 65% at age 70 and to 50% at age 75.

##### Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

- Adaptive Home/Vehicle Benefit
- Rehab Benefit
- Air Bag and Seat Belt
- Spouse and Child Education
- Coma
- Day Care
- Exposure and Disappearance
- Felonious Assault

### Additional Benefits

- **Travel Assistance**  
When traveling 100 or more miles away from home, or outside of your home country, you can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world.
- **Repatriation**  
If death occurs more than 100 miles from your primary residence, a benefit may be payable to prepare and ship your body to the place of burial or cremation.
- **Seat Belt**  
If you die in an automobile accident and were wearing your seat belt, your beneficiary(ies) will collect an amount equal to the AD&D benefit to a maximum of \$10,000 in addition to the Basic Life and Basic AD&D benefits described above.

### Limitations & Exclusions

- **Life:** No restrictions or exclusions regarding time, place or circumstances of death.
- **AD&D** benefits are not payable for death or dismemberment caused by or as result of:
  - suicide, self-inflicted injuries, or such attempts;
  - active participation in a riot;
  - war or act of war;
  - military service for any country;
  - committing or attempting to commit an assault or felony;
  - sickness, disease or pregnancy or any medical treatment for sickness, disease or pregnancy;
  - heart attack or stroke;
  - bodily infirmity or disease from bacterial or viral infections not the result of an injury;
  - taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed and used/consumed in accordance with the directions of the prescribing physician or administered by a licensed physician;
  - travel, flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight;
  - the insured Employee's intoxication

LifeMapCo.com  
1 (800) 794-5390

# welcome to your Employee Assistance Program (EAP)

**We're here to coach and guide you through the challenges in your life. Call your EAP—we can help!**

## OUR SERVICES INCLUDE SUPPORT FOR:

- Anxiety and Depression
- Couples/Relationship/ Parenting
- Crisis Support
- Alcohol/Drug Problems
- Grief and Loss
- Work Conflict
- Compulsive Behaviors
- Domestic Violence
- Legal and Financial
- Childcare and Eldercare
- Home Ownership
- ID Theft
- Healthy Living Tips

## CONTACT US

*Your free and confidential EAP is always available to assist you!*

**(800) 777-4114**  
**FirstChoiceEAP.com**

Your company's complimentary EAP program is available 24/7 and covers employees, spouses, domestic partners, and children up to age 26. The EAP is here to help when you're facing issues that interfere with your health, well-being, and productivity at home or at work.

The EAP offers up to **4 face-to-face visits** (no co-pay, deductible, or premium) with a qualified clinical expert who can assess your concerns and develop a plan of action. If you need a legal\* or financial consultation, or ID theft resolution, you can speak with an expert for up to 30 minutes at no charge. EAP consultants can also provide you with childcare and eldercare information and resources for anywhere in the country. Additionally, the Home Ownership program is a valuable tool to gain a competitive edge as a buyer, and can save you thousands when buying or selling a home.

Simply call us at (800) 777-4114 or visit our website to request an appointment.

**FREE / CONFIDENTIAL / AVAILABLE 24/7**



**Online Tools & Resources**

Login [www.FirstChoiceEAP.com](http://www.FirstChoiceEAP.com)

👍 Username: biaw

*Mobile-friendly searchable database of resources, healthy tips and recipes, parenting advice, legal forms, and more.*

**First Choice Health™**

Healthy Employees. Healthy Companies.™



\*Workplace issues are excluded.

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