2024 SUMMARY PLAN DESCRIPTION FOR:

MACHINISTS HEALTH AND WELFARE TRUST FUND

Group Number: 10009613

Plan 13

Regence

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

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)

VSP provides administration for your Regence vision plan. For VSP vision services, contact:
VSP 1-844-299-3041 (TTY: 1-800-428-4833)

If you believe that Regence or VSP 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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

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

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

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

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

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

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

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

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

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

Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "Plan") provided for You by the Machinists Health and Welfare Trust Fund. The Machinists Health and Welfare Trust Fund has chosen Regence BlueShield to administer claims for Your group health plan. Throughout this Summary Plan Description, the Machinists Health and Welfare Trust Fund may be referred to as the "Plan Sponsor."

TRUST PAID BENEFITS

Your Plan is administered by Regence BlueShield (usually referred to as the "Claims Administrator" in this Summary Plan Description). This means that the Machinists Health and Welfare Trust Fund, not Regence BlueShield, pays for Your covered medical services and supplies. Your claims will be paid only after the Machinists Health and Welfare Trust Fund provides Regence BlueShield with the funds to pay Your benefits and pay all other charges due under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Because of their extensive experience and reputation of service, Regence BlueShield has been chosen as the Claims Administrator of Your Plan.

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description is effective August 1, 2024, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueShield and makes it void.

Keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Eligibility and Enrollment, When Coverage Ends, COBRA Continuation of Coverage, and Other Continuation Options sections, where applicable, the terms "You" and "Your" mean the Participant only). The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions section or where they are first used and are designated by the first letter being capitalized.

NON-GRANDFATHERED

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

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

Federal law mandates coverage for certain breast reconstruction services in connection with a covered mastectomy. See Women's Health and Cancer Rights in the General Provisions Section of this Summary Plan Description for details.

TO ELIGIBLE PARTICIPANTS:

We are pleased to present You with this new Summary Plan Description which contains the amended and restated Machinists Health and Welfare Trust Fund ("Trust Fund") benefits plan.

We encourage You to read this Summary Plan Description carefully so that You are familiar with Your plan benefits. If You have any questions, please contact the Administration Office at 1 (206) 441-7574.

Board of Trustees
Machinists Health and Welfare Trust Fund

IMPORTANT

No employer or local union, no representative of any employer or local union, and no individual Trustee is authorized to interpret the Plan, nor can any such person act as an agent of the Board of Trustees to guarantee benefit payments. No agreement between an employer and a union may change, override or

otherwise affect the Plan in any other way, except as the Board of Trustees may permit by resolution and subsequent revision of the Plan underwritten by the Trust Fund.

The Trust Fund provides benefits to the extent that money is available to continue the Agreement with Regence BlueShield. The Plan is not guaranteed to continue indefinitely. The Board of Trustees may authorize amendments to the Plan, including amendments that affect the eligibility rules and the amount and nature of benefits. Amendments may be made on a prospective basis. The Board of Trustees also has the authority to terminate the Plan at any time according to the terms of the Agreement with Regence BlueShield.

If You have any questions regarding this Plan, You may contact the Administration Office. If You have questions regarding Your benefits, please contact the Claims Administrator's Customer Service at 1 (866) 240-9580. Telephone contact with the Administration Office does not guarantee eligibility for benefits or benefit payments.

Please keep the Administration Office informed of any change of address, dependent status, or beneficiary designation. All changes as described in the Eligibility and Enrollment Section of this Summary Plan Description should be submitted to the Administration Office on an enrollment form or on subsequent change forms.

The Trust Fund has chosen Regence BlueShield to administer the benefits of this health plan.

Using Your Summary Plan Description

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

You control Your out-of-pocket expenses by choosing Your Provider under three choices called: "Category 1," "Category 2" and "Category 3."

- **Category 1:** You see a preferred Provider. Your out-of-pocket expenses will be lower when choosing a preferred Provider and You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 2:** You see a participating Provider. Choosing this category means Your out-of-pocket expenses will generally be higher than for Category 1 because larger discounts with preferred Providers may be negotiated. You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 3:** You see a Provider that does not have a participating contract with the Claims Administrator. Choosing this category means You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing.

For each benefit, this Summary Plan Description indicates the Provider You may choose and Your payment amount. Definitions of each Provider type are in the Definitions section. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF PARTICIPATION

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

- **Go to regence.com** or the Claims Administrator's mobile application. You can use the Claims Administrator's secure applications to:

    - view recent claims, benefits and coverage;
    - 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; and
    - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. The Claims Administrator has contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*Note that if You choose to access these discounts, You may receive savings on an item or service that is covered by Your health plan, that also may create savings or administrative fees for the Claims Administrator. Any such discounts or coupons are complements to the group health plan, but are not insurance.

Enhanced Services, Support, and Access

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

- **Enhanced convenience and options for access to medical care.** These may include additional resources for You to receive covered medical care, such as enhanced virtual care options that are integrated with Your telehealth, telemedicine, Durable Medical Equipment, preventive, behavioral health, and/or other benefits. You may also be offered increased ease in accessing non-Covered Services, such as Cosmetic services or in integrating care for complex and multi-Provider conditions.
- **Healthcare and vitality assistance tools.** You may have tools that enable You to make and track medical appointments; manage health care expenses; receive support in caring for others; remember to timely refill prescriptions and perform regular self-care; track weight, food, and exercise statistics and more.
- **Non-medical lifestyle enhancements.** These may include access or assistance with non-medical services, such as resilience, mindfulness, yoga or stress reduction programs, and pet wellness and insurances services.

Your Plan's enhancements can be accessed through a single sign-on by visiting the Claims Administrator's website, or by contacting Customer Service. These services are specialized and may change over time. Your use of these additional services selected by Your Plan Sponsor is voluntary. In some cases, the Claims Administrator may have an affiliation with the entity that performs the services purchased by Your Plan Sponsor. The use of these services may result in savings or value to You, Your Plan Sponsor, and the Claims Administrator. **ANY SUCH ENHANCED SERVICES, SUPPORT, AND ACCESS ARE COMPLEMENTS TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

CLAIMS ADMINISTRATOR'S CONTACT INFORMATION

- **Call Customer Service:** 1 (866) 240-9580 (TTY: 711) if You have questions, would like to learn more about Your Plan, have not received or have lost Your Plan identification card, or would like to request written or electronic information. Phone lines are open Monday-Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.
- **Visit the Claims Administrator's website at: regence.com.**
- **For assistance in a language other than English,** call the Customer Service telephone number.
- **Call Case Management:** 1 (866) 543-5765 to request that a case manager be assigned to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers.
- **BlueCard® Program.** Call Customer Service to learn how to access care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

Table of Contents

Understanding Your Benefits

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 benefits may have a specific Maximum Benefit. Benefits are covered until the specified Maximum Benefit (which may be a number of days, visits, services, dollar amount, or specified time period) has been reached.

Amounts You pay toward Your Deductible also apply to any specified Maximum Benefit.

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

DEDUCTIBLES

The Deductible (if any) is the amount You are required to pay for Covered Services before the Plan begins to pay benefits for Covered Services in a Calendar Year.

COPAYMENTS

A Copayment is a flat dollar amount that You generally pay directly to the Provider at the time You receive a specified service. Copayments are not applied toward any Deductible.

Refer to the Medical Benefits section to understand what Copayments You are responsible for.

COINSURANCE

Once You have satisfied any applicable Deductible and Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. The percentage You pay varies, depending on the service or supply You received. Refer to the Medical Benefits section for Coinsurance amounts You pay.

The Plan does not reimburse Providers for charges above the Allowed Amount, except where otherwise noted in the Medical Benefits section. A preferred or participating Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount if You choose Category 1 or Category 2. Nonparticipating Providers may bill You for any balances over the Plan payment level in addition to any Deductible, Copayment and/or Coinsurance amount (referred to as balance billing), if You choose Category 3.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You have to pay for Covered Services in a Calendar Year. The Out-of-Pocket Maximum is met by payments of Copayments and/or Coinsurance for Category 1 services and Prescription Medications as indicated in the Medical Benefits section. Once the Out-of-Pocket Maximum is reached, benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. Calendar Year Out-of-Pocket Maximums are specified in the Medical Benefits section.

The Calendar Year Out-of-Pocket Maximum is available on a per Claimant and a per Family basis. For the Family Calendar Year Out-of-Pocket Maximum amount, one Claimant will not contribute more than the individual Out-of-Pocket Maximum amount.

Amounts You pay for non-Covered Services, Category 2 and 3 services, Repair of Teeth, Temporomandibular Joint (TMJ) Disorders, and amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your cost-sharing for Prescription Medications resulting from the use of a drug manufacturer coupon may not count toward the Out-of-

Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

HOW BENEFITS RENEW

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

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

Some benefits may have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year. Those exceptions are noted in the Medical Benefits section.

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 Summary Plan Description is designed to restrict Your choice of Provider for care or treatment of an Illness or Injury.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. Benefits for Gender Affirming Treatment for gender dysphoria 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. A Health Intervention may be medically indicated or otherwise Medically Necessary, yet not be a Covered Service. In some cases, benefits or coverage may be limited to a less costly and Medically Necessary alternative item. See the Definitions section for descriptions of Medically Necessary and of the kinds 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 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 the website or contact Customer Service.

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

CASE MANAGEMENT

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

PREAUTHORIZATION

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

A complete list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Claims Administrator's website at: https://www.regence.com/web/regence_provider/pre-authorization or by calling 1 (866) 240-9580.

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

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

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

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

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

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

CALENDAR YEAR DEDUCTIBLES
Not applicable

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
Category 1
Per Claimant: $1,000
Per Family: $3,000

Categories 2 and 3
Unlimited

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 the website or contact Customer Service.

If You choose to access new medical supplies, equipment, and devices through the website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or

You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

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

Preventive Care

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Preventive care services provided by a professional Provider, facility or Retail Clinic are covered 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/m2 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;
- immunizations for the purpose of travel, occupation, or residency in a foreign country;
- one 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; and
- Food and Drug Administration (FDA) approved women's sterilization methods, contraceptive devices and implants (including the insertion and removal of those devices and implants) in accordance with HRSA recommendations including, but not limited to, condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization (tubal ligation).

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:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Immunizations for adults are covered according to, and as recommended by, the USPSTF and the CDC.

Immunizations - Childhood

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** You pay 0% of the Allowed Amount and You pay any balance of billed charges.

Immunizations for children (through 18 years of age) are covered according to, and as recommended by, the USPSTF and the CDC.

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** After $10 Copayment per visit, You pay 40% of the Allowed Amount.	**Payment:** After $10 Copayment per visit, You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

OUTPATIENT RADIOLOGY AND LABORATORY SERVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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.

Diagnostic and supplemental breast examinations (including mammography) are also covered and services received from a preferred or participating Provider are not subject to any cost-sharing.

"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.

PROFESSIONAL SERVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and may be balance billed.

Professional services and supplies include the following:

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

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

Services and supplies also include:

- treatment of a congenital anomaly;
- Virtual Care service Facility Fees;
- 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. Voluntary second surgical opinions (which may include office visits, review of pathology/radiology reports or radiological services) are covered and are not subject to any Deductible or Coinsurance.

Additionally, certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

Professional Inpatient
Professional inpatient or comparable mobile visits for treatment of Illness or Injury are covered. If You are admitted as an inpatient to a Category 1 Hospital and the admitting Practitioner also is Category 1, then benefits for associated Covered Services provided during the admission by a Category 2 or 3 Hospital-based Practitioner (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) are eligible for coverage at the Category 1 level. Contact Customer Service for further information and guidance.

Radiology and Laboratory (Inpatient)
Diagnostic services and 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).

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

Treatment of varicose veins is only covered when there is:

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

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

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

ACUPUNCTURE

Category: 1	Category: 2	Category: 3
Provider Preferred	**Provider Participating**	**Provider Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: 12 visits per Claimant per Calendar Year		

Acupuncture visits are covered. For acupuncture to treat Substance Use Disorder Conditions, refer to the Substance Use Disorder Services benefit in this Medical Benefits section.

AMBULANCE SERVICES

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

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger Your health and the transportation is not for personal or convenience purposes. Covered Services include licensed ground and air ambulance Providers. Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group and Your identification numbers.

AMBULATORY SURGICAL CENTER

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: After $30 Copayment per visit, You pay 20% of the Allowed Amount. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** After $30 Copayment per visit, You pay 40% of the Allowed Amount.	**Payment:** After $30 Copayment per visit, You pay 40% of billed charges.

Outpatient services and supplies are covered, including professional services and facility charges, for an Ambulatory Surgical Center for Illness and Injury.

APPROVED CLINICAL TRIALS

If You are accepted as a trial participant in an Approved Clinical Trial, Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits 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 Claimant not enrolled in a clinical trial, but do not include:

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

BLOOD BANK

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

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

DENTAL HOSPITALIZATION

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefits. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefits.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefits

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

DETOXIFICATION

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefits.	**Payment:** You pay 0% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 0% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.

Medically Necessary detoxification services are covered.

DIABETIC EDUCATION

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.

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

DIALYSIS – INPATIENT

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.

Inpatient services and supplies for dialysis not related to the Dialysis – Outpatient Program are covered.

DIALYSIS – OUTPATIENT

Outpatient Initial Treatment Period

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.
Outpatient Limit: three months per Claimant (42 treatments of hemodialysis or 30 days peritoneal dialysis) for the initial treatment period		

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

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

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

Outpatient Supplemental Treatment Period (Following Initial Treatment Period)

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Plan, the Plan pays 100% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Plan, the Plan pays 100% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** The Plan pays 150% of the Medicare allowed amount at the time of service. If You are not enrolled in Medicare Part B, You pay the balance of billed charges, which will not apply toward the Out-of-Pocket Maximum.

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

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

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

Case Managed Dialysis and Supplemental Kidney Dialysis Program

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

To learn more or to enroll in Case Management, call 1 (866) 240-9580.

DURABLE MEDICAL EQUIPMENT

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes (such as insulin pumps and therapeutic continuous glucose monitors, 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 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 find ways to access new Durable Medical Equipment, including how to access an approved Commercial Seller, visit the website or contact Customer Service. If You choose to access new Durable Medical Equipment through the website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

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

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $30 Copayment per visit. The Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** You pay $30 Copayment per visit. The Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** You pay $30 Copayment per visit. The Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

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

"Stabilization" means to provide Medically Necessary treatment:

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

If You are admitted to 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.

FAMILY PLANNING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Certain professional Provider contraceptive services and supplies are covered under this benefit, including, but not limited to, vasectomy.

For coverage of prescription contraceptives, please see the Prescription Medications benefit. You are not responsible for any applicable Coinsurance when You fill prescriptions for FDA-approved contraceptives prescribed by Your health care Provider. For a list of such medications, please visit the website or contact Customer Service.

For more information on preventive services for women, including HIV screening, HPV DNA testing, tubal ligation, insertion or extraction of FDA-approved contraceptive devices, and certain patient education and counseling services, see the Preventive Care and Immunizations benefit of this Summary Plan Description or for a list of covered preventive services, please visit the website or contact Customer Service.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: All Other Providers
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** 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 the Claims Administrator 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.

GROWTH HORMONE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

The Plan covers services and supplies for growth hormone treatment when provided by an infusion therapy Provider for the following: 1) for children with growth hormone deficiency, Turner's syndrome, chronic renal insufficiency, Prader-Willi syndrome, neonatal hypoglycemia associated with growth hormone deficiency, or for other conditions determined to be a covered benefit since this Summary Plan Description was issued; and 2) for adults with growth hormone deficiency as a result of hypothalamic or pituitary disease due to destructive lesion of the pituitary, or peri-pituitary area, as a result of treatment or surgery, or for other conditions determined to be a covered benefit since this Summary Plan Description was issued. No benefits for growth hormones will be provided unless authorized in advance by the Claims Administrator.

HOME HEALTH CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: 130 visits per Claimant per Calendar Year		

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

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

HOME PHOTOTHERAPY

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 0% of the Allowed Amount and You pay any balance of billed charges.

Services and supplies furnished by a home phototherapy Provider for newborn hyperbilirubinemia (newborn jaundice) are covered.

HOSPICE CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.
Limit: 14 inpatient or outpatient respite care days per Claimant Lifetime		

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

Respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant is covered.

Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Inpatient Services

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: After $200 Copayment per admission, You pay 20% of the Allowed Amount. The Copayment is waived if You are readmitted within 90 days. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** After $200 Copayment per admission, You pay 40% of the Allowed Amount. The Copayment is waived if You are readmitted within 90 days.	**Payment:** After $200 Copayment per admission, You pay 40% of the Allowed Amount and You pay any balance of billed charges. The Copayment is waived if You are readmitted within 90 days.

Outpatient Services

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Inpatient and outpatient services and supplies of a Hospital are covered for Illness and Injury (including Prescription Medications and services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary.

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

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Services, supplies and medications for infusion therapy, including home infusion therapy and infusion pumps. Home infusion therapy includes parenteral or enteral therapy.

MATERNITY CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions, and Medically Necessary supplies for home birth are covered for a Participant or an enrolled spouse or domestic partner. 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. Termination of pregnancy and related conditions are covered (to the extent such services are permitted under applicable law), not subject to cost-sharing for In-Network Providers.

Additionally, the Plan will cover enrolled children for complications of pregnancy, including:

- fetal distress;
- gestational diabetes; and
- toxemia.

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 the Plan the lesser of the amount described in the preceding sentence and the amount the Plan paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under the Plan).

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

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 0% of the Allowed Amount and You pay any balance of billed charges.

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

MENTAL HEALTH SERVICES

Inpatient Services

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.

Outpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

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

Definitions

The following definitions apply to this Mental Health Services benefit:

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

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

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

NEURODEVELOPMENTAL THERAPY

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.
Outpatient Limit: 17 professional visits per Claimant 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 Claimant's condition would result without the service.

You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

NUTRITIONAL COUNSELING

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

ORTHOTIC DEVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

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

Reimbursement may also be available for new orthotic devices when purchased new from an approved Commercial Seller, even though that seller is not a Provider. Eligible new orthotic devices purchased through an approved Commercial Seller are covered at the Category 1 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 the website or contact Customer Service. If You choose to access new orthotic devices through the website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

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

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

PALLIATIVE CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: 30 visits per Claimant per Calendar Year		

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

PRESCRIPTION MEDICATIONS

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 the Claims Administrator's website or contact Customer Service.

You are responsible for paying the following Coinsurance amounts and any applicable Deductible, at the time of purchase, if the Pharmacy submits the claim electronically. Your cost-sharing will be applied toward the Out-of-Pocket Maximum. See below for information on claims that are not submitted electronically and for information on maximum quantities. You do not need to meet any Deductible and/or Coinsurance when You fill a prescription for a Self-Administrable Cancer Chemotherapy Medication or a Prescription Medication on the Opioid Rescue Medication Value List. Insulin is not subject to any Deductible and Your Coinsurance for insulin will not exceed $35 per 30-day supply or $105 per 90-day supply. Your Coinsurance for insulin will be applied to Your Deductible.

Prescription Medications from a Pharmacy

- **Tier 1:** After Deductible, You pay 0% Coinsurance.
- **Tier 2:** After Deductible, You pay 20% Coinsurance.
- **Tier 3:** After Deductible, You pay 20% Coinsurance.
- **Compound Medication:** After Deductible, You pay 20% Coinsurance.

Prescription Medications from a Home Delivery Supplier

- **Tier 1:** After Deductible, You pay 0% Coinsurance.
- **Tier 2:** After Deductible, You pay 20% Coinsurance.
- **Tier 3:** After Deductible, You pay 20% Coinsurance.
- **Compound Medication:** After Deductible, You pay 20% Coinsurance.

Specialty Medications

- Same cost-sharing listed above for Tier 2 and Tier 3 Prescription Medications from a Pharmacy. The first fill is allowed at a retail Pharmacy. Additional fills must be purchased from a Specialty Pharmacy.

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 the website or by calling Customer Service. The cost share amounts noted in this Prescription Medications benefit 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 the Claims Administrator's prior authorization department by phone as it is outside of business hours; or
- the Claims Administrator is 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 insulin pumps, and their supplies, that are on the Drug List may be purchased from a Participating Pharmacy, when obtained with a Prescription Order; therapeutic continuous glucose monitors and insulin pumps, and their supplies, are also covered in the Medical Benefits Section;
- 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 Opioid Rescue Medication Value List found on the website or by calling Customer Service;
- Compound Medications (preauthorization may be required);
- Self-Administrable Cancer Chemotherapy Medication;
- Self-Administrable Prescription Medications including, but not limited to, Self-Administrable Injectable Medications and teaching doses (by which a Claimant is educated to self-inject); 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;
- 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 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. NOTE: The applicable Deductible and/or Coinsurance will apply for preventive medications, contraceptives and immunizations from a Nonparticipating Pharmacy.

If Your Provider believes that the 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 the website 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 MEDICATION COST-SHARE ASSISTANCE

Your Plan Sponsor has coordinated with an alternate funding service to provide a cost-share assistance program for a select list of Prescription Medications. The program is separate from Your benefits under this Plan and is designed to reduce or eliminate any out-of-pocket expenses for qualifying Prescription Medications. If You are eligible to participate, the Claims Administrator will contact You and help You enroll. Upon enrollment in the program, a review will be conducted to locate cost-sharing assistance for You based on Your specific Prescription Medication. If cost-sharing assistance is identified and You are eligible but choose not to enroll, You will be responsible for any Deductible, Copayment, and/or Coinsurance as explained in this Prescription Medications Section. Whether You choose to enroll in the program or not, Your cost-sharing responsibility under this Prescription Medication Benefit will remain the same throughout the Calendar Year.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Preauthorization

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

Drug List Changes

Any removal of a Prescription Medication from the Drug List will be posted on the Claims Administrator's website 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, the Plan will continue to cover Your Prescription Medication for the time period required to use the 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 the Claims Administrator 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 the Claims Administrator's website. You or Your Provider may request preauthorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's website.

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 Plan and will apply toward any Deductible or Out-of-Pocket Maximum.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on the Claims Administrator's website or by contacting Customer Service. There are more than 1,200 Participating Pharmacies in the Claims Administrator's Washington State network from which to choose.

You must present Your identification card to identify Yourself as a Claimant 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, the Nonparticipating Pharmacy will be paid 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 the Claims Administrator. To find the Prescription Medication claim form, visit the Claims Administrator's website or contact Customer Service.

You will be reimbursed 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

You can also 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 the Claims Administrator's website:

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

Prescription Medications Dispensed by Excluded Pharmacies

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

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

Refills
Refills obtained from:

- a Pharmacy are covered when You have taken 75 percent of the previous prescription 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 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 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 may not apply toward the Deductible and Out-of-Pocket Maximum.

Limitations
The following limitations apply to this Prescription Medications benefit, except for preventive medications as specified in the Covered Preventive Medications, Contraceptives and Immunizations provision:

Maximum 30-Day or Greater Supply Limit
- **Injectable Medications and 90-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Home Delivery Supplier is a 90-day supply.
- **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Pharmacy or Specialty Pharmacy 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, please visit the website or contact Customer Service. Specialty medications are not allowed through Home Delivery Suppliers.
- **Home Delivery and 90-Day Supply.** 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.
- **Participating Pharmacy and 100-Day Supply.** Except as specifically provided, the largest allowable quantity of a Prescription Medication that You may purchase from a Participating Pharmacy is a 100-day supply. A Provider may prescribe, or You may purchase, some medications in smaller quantities.
  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 100-day supply (even if the manufacturer packaging includes a larger supply).
- **Nonparticipating Pharmacy and 30-Day Supply.** Except as specifically provided, 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. A Provider may prescribe, or You may purchase, some medications in smaller quantities.

Maximum Quantity Limit
For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of

medication that will be covered during a period of time. The Claims Administrator uses information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.

For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Claimant's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.

The Plan does not cover any amount over the established maximum quantity, except if the Claims Administrator determines the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

EXCLUSIONS

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

Biological Sera, Blood or Blood Plasma

Bulk Powders

Non-FDA approved bulk powders that are not included on the Claims Administrator's Drug List (which requires a Prescription Order by a Physician or Practitioner).

Cosmetic Purposes

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

- removal, inhibition or stimulation of hair growth, except as related to a covered medical condition;
- anti-aging; or
- repair of sun-damaged skin.

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

Medications used to aid in diagnosis rather than treatment. Coverage for these medications may otherwise be provided under the Medical Benefits.

Digital Therapeutics

Except as included on the Claims Administrator's 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

Coverage for general anesthetics may otherwise be provided under the Medical Benefits.

Growth Hormones
Coverage for growth hormones is provided under the Growth Hormone benefit if preauthorized by the Claims Administrator.

Medical Foods
Coverage for these products may otherwise be provided under the Medical Benefits.

Non-Self-Administrable Medications
Coverage for these medications may otherwise be provided under the Medical Benefits or as specifically indicated in this Prescription Medications benefit.

Nonprescription Medications
Medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements, except medications included on the Claims Administrator's Drug List, approved by the FDA, and prescribed by a Physician or Practitioner licensed to prescribe Prescription Medications. This includes 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. Coverage for these medications may otherwise be provided under the Medical Benefits. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications for the Treatment of Infertility

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

Prescription Medications Not Approved by the FDA

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

Prescription Medications Not on the Drug List
Except as provided through the Drug List Exception Process provision, 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 benefit:

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 the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Drug List. It is available on the Claims Administrator's website or by calling Customer Service. Medications are reviewed and selected for inclusion on the 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 Claimant 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, the Claims Administrator will decide.

Home Delivery Supplier means a home delivery Pharmacy with which the Claims Administrator has contracted for home delivery services.

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

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

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

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

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works and its 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, all of whom are free from conflict of interest of drug manufacturers and the majority of whom are free from conflict of interest of Your coverage, who review the medical and scientific literature regarding medication use and provide input and oversight of the development of the Drug List and medication policies.

Prescription Medications and Prescribed Medications means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included on the Claims Administrator's Drug List.

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

Self-Administrable Prescription Medications, Self-Administrable Medications, Self-Administrable Injectable Medications, or Self-Administrable Cancer Chemotherapy Medications means Prescription Medications 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 office or clinic). For the purposes of this definition, 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. Your status, such as Your ability to administer the medication, will not be considered when determining whether a medication is self-administrable.

Specialty Medication means a medication that may be used to treat complex conditions, including, but not limited to, multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit the website or contact Customer Service at 1 (866) 240-9580.

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit the Claims Administrator's website 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 3 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 and Specialty 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 and Specialty Medications that are categorized based on how well they work and/or their cost compared to other medications that treat the same condition.

PROSTHETIC DEVICES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% 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 Claimants who have had a mastectomy, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital inpatient care, Hospital outpatient care, or Ambulatory Surgical Center care) in this Medical Benefits Section. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.

RECONSTRUCTIVE SERVICES AND SUPPLIES

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefit.

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 in this Summary Plan Description.

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

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.
Inpatient limit: 41 days per Claimant per Calendar Year **Outpatient limit:** 40 visits per Claimant per Calendar Year		

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

You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center or Hospital Care – Inpatient and Outpatient benefit.
Limit: $1,000 per Claimant per Calendar Year		

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

SKILLED NURSING FACILITY (SNF) CARE

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: 100 inpatient days per Claimant per Calendar Year		

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

SPINAL MANIPULATIONS

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment.	**Payment:** After $10 Copayment, You pay 40% of the Allowed Amount.	**Payment:** After $10 Copayment, You pay 40% of the Allowed Amount and You pay any balance of billed charges.
Limit: ten spinal manipulations per Claimant per Calendar Year		

Chiropractic and osteopathic spinal manipulations performed by a Provider are covered. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits in this Medical Benefits Section.

SUBSTANCE USE DISORDER SERVICES

Inpatient Services

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit. **Professional Payment:** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Hospital Care – Inpatient and Outpatient benefit.

Outpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

Coverage for treatment of Substance Use Disorder Conditions includes the following:

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

Definitions

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

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

Substance Use Disorder Conditions means substance-related disorders included in the most recent edition of the 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 court ordered treatment (unless the treatment Medically Necessary).

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

Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount. Office visits are subject to $10 Copayment. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center and Hospital Care – Inpatient and Outpatient benefits.	**Payment:** You pay 20% of the Allowed Amount. Office visits are subject to $10 Copayment. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center and Hospital Care – Inpatient and Outpatient benefits.	**Payment:** You pay 20% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center and Hospital Care – Inpatient and Outpatient benefits.

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

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

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

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

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

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

TRANSPLANTS

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Facility Payment: You pay 20% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center and Hospital Care – Inpatient and Outpatient benefits. **Professional Payment** You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center and Hospital Care – Inpatient and Outpatient benefits.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges. Facility charges may be subject to Copayment as specifically indicated in the Ambulatory Surgical Center and Hospital Care – Inpatient and Outpatient benefits.

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

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

For a list of covered transplants, contact Customer Service, as the list is subject to change. 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.

Transplant Waiting Period

You will not be eligible for any benefits related to a transplant until the first day of the 13th month of continuous coverage under this or any previous medical plan with the Claims Administrator, whether or not the condition is preexisting.

The duration of the transplant waiting period will be reduced by the amount of Your combined periods of creditable coverage if You have been covered by creditable coverage. For crediting to apply for more than one creditable coverage, there must have been no break in creditable coverage greater than 63

days immediately preceding Your enrollment date of coverage under the Plan or between any two successive creditable coverages for which You seek credit. For the purpose of the transplant waiting period, creditable coverage also includes one immediately previous and otherwise creditable coverage that terminated in the period beginning 90 days and ending 64 days before the date of application for coverage under the Plan. Creditable coverage may still be in force at the time credit for it is sought on this coverage.

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

Creditable coverage is determined separately for each Claimant.

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

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

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

VIRTUAL CARE

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

Some Providers or virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

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

Store and Forward Services

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

- telephone;
- facsimile (fax);

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

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

Telehealth

Category 1	Category 2	Category 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount.	**Payment:** You pay 40% of the Allowed Amount and You pay any balance of billed charges.

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

General Exclusions

The following are the general exclusions from coverage. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

SPECIFIC EXCLUSIONS

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

Activity Therapy

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 Summary Plan Description.

Assisted Reproductive Technologies

Assisted reproductive technologies (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 or other artificial means of conception), or associated surgery, medications, testing or supplies, regardless of underlying condition or circumstance.

Certain Therapy, Counseling, and Training

Educational, vocational, social, image, self-esteem, milieu or marathon group therapy, premarital or marital counseling, employee assistance program services; job skills or sensitivity training.

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Cosmetic Services and Supplies
This exclusion does not apply to services that are prescribed as Medically Necessary for Gender Affirming Treatment and are in accordance with accepted standards of care.

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

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

Dental Services
Dental Services and supplies 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. This exclusion does not apply to dental services described under the Repair of Teeth benefit.

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

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

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

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

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

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

Hearing Aids, and Other Hearing Devices
Hearing aids (externally worn or surgically implanted) and other hearing devices, except for cochlear implants.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, mental health and 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 Claimant's voluntary participation in an activity where the Claimant 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, the Plan may recover the payment from the person 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.

Individual Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids, services and supports provided under an individualized education plan developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility Treatment
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 Coverage and Other Insurance Liability
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to the Summary Plan Description.

Non-Direct Patient Care
Services that are not considered direct patient care or virtual care including charges for:

- appointments scheduled and not kept ("missed appointments");
- preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges), except as provided under the Virtual Care benefit.

Non-Therapeutic Continuous Glucose Monitors

Obesity or Weight Reduction/Control
The Plan does not cover medical treatment, medications, surgical treatment (including revisions, reversals, and treatment of complications), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions, except as provided for in the Nutritional Counseling benefit or to the extent Covered Services are required as part of the USPSTF, HRSA, or CDC requirements or as required by law.

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.

Over-the-Counter Contraceptive Supplies
Over-the-counter contraceptive supplies, except as covered under the Prescription Medications benefit.

Personal Items
Items that are primarily for comfort, convenience, contentment, Cosmetics, hygiene, environmental control, education or general fitness. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes, weight lifting equipment, and therapy or service animals, including the cost of training and maintenance, are not covered.

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

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

Reversal of Sterilization
Services and supplies related to reversal of sterilization.

Routine Foot Care

Routine Hearing Exams
Routine hearing exams, except as provided in the Hearing Care Endorsement, if any.

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

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. "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 share 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, such as laboratory or similar tests required by an employer or, primarily for administrative or qualification purposes. Such purposes include, but are not limited to, admission to or remaining in a school, camp, the military or other institution; legal proceedings, such as establishing paternity or custody; qualification for employment or return to work, marriage, insurance, occupational injury benefits, licensure or certification; or travel, immigration or emigration.

Sexual Dysfunction
Treatment, services and supplies for or in connection with sexual dysfunction, regardless of cause, except for covered Mental Health Services.

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

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

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

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

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

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims payment is due, the Claims Administrator decides whether to pay the Claimant, Provider and Claimant jointly, or the Provider directly 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 the Claims Administrator for processing Your claim.

A preferred or participating Provider will be paid directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. 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 the Claims Administrator to pay for Covered Services, You or the nonparticipating Provider must first send the Claims Administrator a claim. Be sure the claim is complete and includes the following information:

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

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

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

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 the Claims Administrator or as otherwise required by law.

Timely Filing of Claims

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

Claims Determinations

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

extenuating circumstances. You will be notified of the extension within the initial 30-day period and provided an explanation of why the extension is necessary.

If additional information is required to process the claim, You will be allowed at least 45 days to provide it. If the Claims Administrator does not receive the requested information within the time allowed, the claim will be denied.

CONTINUITY OF CARE

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

To qualify for continued coverage, You must be:

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

The Claims Administrator will notify You of Your right to receive continued care from the Provider or You may contact the Claims Administrator with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Plan and provided on the same terms and conditions as any other 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 the Claims Administrator's Customer Service for further information and guidance.

OUT-OF-AREA SERVICES

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

When You receive care outside of the Claims Administrator's Service Area, You may receive it from Providers as described below. Providers contracted with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the 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 will not 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. The section below explains how the Plan pays these different kinds of Providers.

BlueCard Program

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

When Covered Services are received outside the Claims Administrator's Service Area and the claim is processed through the BlueCard Program, the amount the Claimant pays for Covered Services is calculated based on the lower of:

- the billed charges for the Covered Services; or

- the negotiated price that the Host Blue makes available to the Claims Administrator.

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

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

Value-Based Programs

If Covered Services are received under a Value-Based Program inside a Host Blue's service area, the Claimant 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 the Claims Administrator 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 self-funded accounts. If applicable, any such surcharge, tax or other fee will be included as part of the claim charge passed on to the Claimant.

Nonparticipating Providers Outside the Claims Administrator's Service Area

- Liability Calculation. When Covered Services are provided outside of the Claims Administrator's Service Area by nonparticipating Providers, the amount the Claimant pays 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, the Claimant may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment that will be made 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, other payment methods may be used, such as billed covered charges, the payment that would have been made if the health care services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment to determine the amount that will be paid for services provided by nonparticipating Providers. In these situations, the Claimant may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although 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 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 Services.

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

CLAIMS RECOVERY

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

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

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

SUBROGATION AND RIGHT OF RECOVERY

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

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Injury, Illness or condition for which the Plan has paid medical claims

(including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers Compensation coverage, no fault automobile coverage or any first party insurance coverage).

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

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

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

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

Assignment

In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have 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.

First-Priority Claim

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

Applicability to All Settlements and Judgments

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

Cooperation

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

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health Plan's subrogation and reimbursement interest.

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

Workers' Compensation

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

Future Medical Expenses

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

Interpretation

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

Jurisdiction

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your

present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

COORDINATION OF BENEFITS

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

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

Definitions

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

Other Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no 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.

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

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

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

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

When This Plan is primary, it determines payment for its benefits first before those of any Other Plan without considering any Other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the same Allowable Expense that this Plan would have paid if it were the Primary Plan. When the Primary Plan is Medicare and This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the Medicare Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for You. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an Allowable Expense

under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its Maximum Benefit plus any accrued savings.

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

When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the Allowable Expense.

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

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

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

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

Order of Benefit Determination Rules

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

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers You other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers You as a dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering You as a dependent, and primary to the plan covering You as other than a dependent (for example, a retired employee), then the order of benefits between the two plans is reversed so that the plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the Other Plan is the Primary Plan.

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

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

- The plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
- If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.

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

  - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree. If benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next contract year;
  - If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
  - If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
  - If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    The plan covering the Custodial Parent, first;
    The plan covering the spouse of the Custodial Parent, second;
    The plan covering the noncustodial parent, third; and then
    The plan covering the spouse of the noncustodial parent, last.

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

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

COBRA or State Continuation Coverage. If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law, the plan covering You as an employee, member, subscriber or retiree or covering You as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the Other Plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage. The plan that covered You as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the plan that covered You the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of This Plan or Other Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of this Plan

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

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

Appeal Process

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

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

WHAT YOU MAY APPEAL

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

Method of Request	Contact Information
Fax	1 (877) 663-7526
Phone	Call the Claims Administrator at 1 (866) 240-9580
Mail	Attn: ASO Appeals and Grievances Regence BlueShield P.O. Box 1106 Lewiston, ID 83501

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

APPEAL DETERMINATION TIMING

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

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

First-Level Internal Appeals
First-level appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals.

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

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO)
A voluntary appeal to an IRO is available only after You have exhausted all of the applicable non-voluntary levels of appeal, or if the Claims Administrator has failed to adhere to all claims and internal appeal requirements. Voluntary external appeals are available for:

- issues involving medical judgment, including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or
- the determination that a treatment is Investigational.

Voluntary external appeals must be requested within four months of Your receipt of the notice of the prior adverse decision. The Claims Administrator coordinates voluntary external appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external appeal by an IRO is optional, and You should know that other forums may be used as the final level of appeal to resolve a dispute You have under the Plan. This includes, but is not limited to, civil action per Section 502(a) of ERISA.

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

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

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

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

The Claims Administrator coordinates voluntary external expedited appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. Choosing the voluntary external expedited appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary external expedited appeal by an IRO is optional and You should know that other forums may be used as the final level of expedited appeal to resolve a dispute You have under the Plan. This includes, but is not limited to, civil action under Section 502(a) of ERISA.

INFORMATION

If You have any questions about the appeal process, contact Customer Service at 1 (866) 240-9580 or write to Customer Service at the following address: Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

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

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

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

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

Eligibility and Enrollment

This Plan is maintained for employees whose employers are required to contribute to the Machinists Health and Welfare Trust Fund pursuant to a collective bargaining agreement between the employer and I.A.M. District Lodge 160, or any other labor organization approved by the Board of Trustees, or by special or non-bargaining agreement. Non-bargaining unit employees may be subject to their employer's probationary periods. In this Summary Plan Description, references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Eligibility and Enrollment and Other Continuation Options Sections, the terms "You" and "Your" mean the Participant only).

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents under the eligibility requirements in effect with the Plan Sponsor.

Employees

The Trust Fund maintains a lag month eligibility system. Active employees who are compensated for at least 80 hours during a work month will be eligible for coverage on the first day of the second month following the work month (except as described below) when contributions are made to the Trust Fund on their behalf. Thereafter, You will be eligible on the first day of the second month following the month during which You were compensated for 80 hours:

If You are compensated for 80 hours in this month	Lag	You will be eligible for the month of
January February	February March	March April

Coverage will cease at the end of the month immediately following the month in which You fail to be compensated for 80 hours. For information regarding an extension of Your Plan benefits, see the When Coverage Ends Section or contact the Administration Office for details.

Some collective bargaining agreements or area supplements may include eligibility language which differs from the 80-hour requirement included in this Plan. In such cases where the employer is required to make contributions for employees earning less than 80 hours during a work month, the hours or days requirement to make payments included in the collective bargaining agreement or area supplement will prevail. Coverage will be maintained consistent with the lag month eligibility system.

Employer Withdrawals

In some cases, employers have been granted a prior waiver of the lag month eligibility rule and the cost of such waiver was borne by the Trust Fund. Employees of an employer who was granted a prior waiver and who then terminates participation in the Plan for a reason other than plant closure or bankruptcy will lose lag month eligibility. Upon withdrawal, the Trust Fund will recover the lag month and Your coverage will terminate at the end of the month following the last month for which hours are earned and reported to the Trust Fund. For example, if the last contribution received was for work performed in July, and Your employer was previously granted a waiver of the lag month, coverage will end at the end of August. Withdrawal of participation by an employer is an exception to the lag month eligibility illustrated above. In the usual case, COBRA continuation coverage will not be granted to employees and dependents or former employees and their dependents of a withdrawn employer. You should contact the Administration Office if You have questions about eligibility upon termination from the Plan.

Dependents

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

- The person to whom You are legally married (spouse).

- Your registered domestic partner or domestic partner for whom You have submitted an accurate and complete affidavit of qualifying domestic partnership.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:

    - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental or physical disability that began before the child's 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:

    - the child is a Beneficiary immediately before their 26th birthday; or
    - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as a dependent on either a parent's or legal guardian's group coverage since that birthday.

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

NEWLY ELIGIBLE DEPENDENTS

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

SPECIAL ENROLLMENT

Note: The Trust Fund maintains that employees cannot decline coverage when first eligible; any reference in this Special Enrollment provision relating to You (as the employee) declining coverage when first eligible is not applicable.

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

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

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

the qualifying event (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
  - an employer's contributions to that other plan are terminated;
  - exhaustion of federal COBRA or any state continuation; or
  - loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours, or meeting or exceeding the lifetime limit on all benefits of 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 Plan within 30 days from the date of the qualifying event (except that, where the qualifying event is You and/or Your Beneficiary becoming eligible for premium assistance under Medicaid or Children's Health Insurance Program (CHIP), or the Washington State Department of Social and Health Services (DSHS) determination that it is cost-effective for an eligible Beneficiary to have coverage under the Plan, You have 60 days from the date of the qualifying event to enroll):

- You marry or begin a 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 Plan within 60 days from the date of the qualifying event:

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

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

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form to the Administration Office (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. Such information must be received before enrolling a person as a dependent under the Plan.

When Coverage Ends

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

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

AGREEMENT TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

Termination of Your Employment or You are No Longer Eligible

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

Nonpayment

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

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 Beneficiaries will remain eligible to be enrolled under the Plan 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 make payments for coverage through the Plan Sponsor on time. The provisions described here will not be available if the Plan terminates.

If You and/or Your Beneficiaries elect not to remain enrolled during the leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan 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 Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Beneficiaries) will receive credit for any waiting period served before the leave and You will not have to re-serve any probationary period under the Plan.

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 Plan Sponsor must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by an applicable leave.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

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

Divorce or Annulment

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

Death of the Participant

If You die, coverage for Your Beneficiaries ends on the last day of the month following the month in which You are not compensated for 80 hours.

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

Claimants may be terminated for any of the following reasons. However, it may be possible for them to continue coverage under the Plan according to the continuation of coverage provisions.

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional

misrepresentation of material fact or fraud regarding a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan Sponsor), any action allowed by law or contract may be taken, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

COBRA Continuation of Coverage

The following is a brief summary of the continuation of coverage provisions of Federal law, commonly known as COBRA. More detailed information is available from the Administration Office.

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 Beneficiaries (except Your domestic partner and their children) if they lose eligibility because:

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

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

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

General Rules

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

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

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

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

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

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

After You and/or Your Beneficiaries' exhaust COBRA continuation coverage, an Individual policy may be available.

Other Continuation Options

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

Availability of Other Coverage

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

Strike, Lockout or Other Labor Dispute

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

You must pay the full cost, including any part usually paid by the Plan Sponsor, directly to the trust that represents You. The trust must continue to pay the Claims Administrator the payments according to the Agreement. This six months of continued coverage is instead of and not in addition to any continuation of coverage provisions of the Plan.

General Provisions and Legal Notices

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

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

GOVERNING LAW AND DISCRETIONARY LANGUAGE
The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Washington without regard to its conflict of law rules. The Plan Administrator, the Plan Sponsor, delegates the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the Plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a Claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the Plan. Legal action seeking judicial review must commence within 24 months of notification of final decision of the Appeals Process. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan, and the court will determine the level of discretion that it will accord determinations.

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

LIMITATIONS ON LIABILITY
In all cases, You have the exclusive right to choose a health care Provider. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator. Neither the Claims Administrator nor the Plan is responsible for the quality of health care You receive, except as provided by law.

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

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

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

NOTICES

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

NOTICE OF PRIVACY PRACTICES

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER DETERMINATION PROCEDURE

A copy of the procedures governing qualified medical child support order (QMCSO) determinations can be obtained by participants and beneficiaries, without charge, by contacting the Administration Office.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

- billing statements;
- claim records;
- correspondence;

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

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

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

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

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

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

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

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

TAX TREATMENT

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

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

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes only the following companies: Regence 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 full payment for a service or supply.
- For nonparticipating (non-contracted) Providers, the amount the Claims Administrator has determined to be reasonable charges or has negotiated for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

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

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

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

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

Category 1 means the benefit reimbursement level for services that are received from a contracted Provider with the Claims Administrator in Your Provider network who provides services and supplies to Claimants in accordance with the provisions of this coverage. Your Provider network is Preferred and may include the Claims Administrator's Affiliates. Category 1 also means a Provider outside the area that the Claims Administrator or one of the Claims Administrator's 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 the Claims Administrator's 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 the Claims Administrator in Your Provider network who provides services and supplies to Claimants in accordance with the provisions of this coverage. Your Provider network is Participating and may include the Claims Administrator's Affiliates. Category 2 also means a Provider outside the area that the Claims Administrator or one of the Claims Administrator's 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 the Claims Administrator's 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 the Claims Administrator's identified Centers of Excellence for the particular therapy.

Claimant means a Participant or a Beneficiary.

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

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

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

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

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

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

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

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

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

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

"effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-Reviewed Medical Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:

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

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

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

Family means a Participant and any Beneficiaries.

Gender Affirming Treatment means Medically Necessary Covered Services provided by a Provider and prescribed in accordance with generally accepted standards of care to treat gender dysphoria.

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

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

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

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

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

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

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

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

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

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

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

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

Practitioner means a healthcare professional, other than a Physician, who is duly licensed to provide medical or surgical services. Practitioners include, but are not limited to, chiropractors, psychologists, registered nurse practitioners, ARNP's, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and other professionals practicing within the scope of their respective licenses, such as massage therapists, physical therapists and mental health counselors.

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

Regence refers to Regence BlueShield.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include an office or independent clinic outside a retail operation, or an Ambulatory Surgical Center, urgent care center, Hospital, Pharmacy, rehabilitation facility or 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 the Claims Administrator has 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.

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

Appendix: Value-Added Services

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

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

CARE MANAGEMENT

Receive one-on-one help and support in the event You have a chronic, serious or sudden Illness or Injury. An experienced care management nurse will serve as Your single point of contact and personal advocate to help You understand Your Providers' instructions, help prepare You for an elective surgical procedure, assist in coordinating overall care, connecting to special medical expertise and accessing other Plan Sponsor services and programs. Your nurse is supported by a multidisciplinary team made up of doctors, social workers, Pharmacists and behavioral health experts that can be accessed for additional consultation. The goal is to offer assistance in navigating through Your health care needs, including working with Your community resources to provide a personalized touch and to enhance the quality of Your wellbeing. Care management nurses proactively outreach by telephone and educational mailings or You may request support by directly contacting a nurse. To learn more, call 1 (866) 543-5765.

INFUSION SITE OF CARE

If You receive certain infused or injectable drugs, You may be notified about an opportunity to receive Your care at an alternative location. Alternative locations such as standalone infusion sites, doctor's offices and home infusion can offer more comfort, convenience, and reduced costs compared to most Hospital settings. You may contact the Claims Administrator for a list of drugs included in the Infusion Site of Care program or for help finding an alternative location.

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

Summary Plan Description

The Plan is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor. Note that the terms "You" and "Your" in this Summary Plan Description Section by and large refer to the Participant.

PLAN NAME
Machinists Health and Welfare Trust Fund

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR
The plan is sponsored and administered by a joint labor-management Board of Trustees, the name and address of which is:

Board of Trustees of the Machinists Health and Welfare Trust Fund
c/o Welfare and Pension Administration Service, Inc.

Street Address:
7525 SE 24th Avenue Suite 200
Mercer Island, WA 98040

Correspondence Address:
PO Box 34203
Seattle, WA 98124

1 (206) 441-7574 or 1 (800) 732-1121

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS
91-1363505

PLAN NUMBER
501

TYPE OF PLAN
Welfare Benefit Plan: medical benefits.

TYPE OF ADMINISTRATION
The Plan is administered by the joint Board of Trustees, with the assistance of Welfare and Pension Administration Service, Inc., a contract administration organization, the address and phone number of which is listed in Plan Sponsor above.

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS
Each member of the joint Board of Trustees is designated as an agent for purposes of accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are set forth below.

Legal process may also be served upon:

Welfare and Pension Administration Service, Inc.

Street Address:
7525 SE 24th Avenue Suite 200
Mercer Island, WA 98040

Correspondence Address:
PO Box 34203
Seattle, WA 98124

1 (206) 441-7574 or 1 (800) 732-1121

NAME, ADDRESS AND PHONE NUMBER OF BOARD OF TRUSTEES

Union Trustees

Arthur Boulton, Chairman
IAM District Lodge 160, Retired
PO Box 1703
Bothell, WA 98041-1703

Beth Bergeon
IAM District Lodge 160
9135 15th Place South
Seattle WA 98108

Zac Collins
IAM District Lodge 160
9135 15th Place South
Seattle WA 98108

Employer Trustees

Mike Wilson, Secretary
United Parcel Service, Inc.
4455 7th Avenue So.
Seattle, WA 98108

Leauri Moore
Canfisco Group
4 Nickerson St.
Suite 400
Seattle, WA 98109

Dale Schiffler
Peter Pan Seafoods
3015 112th Ave NE Suite 100
Bellevue, WA 98004

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to collective bargaining agreements. You may obtain a copy of the pertinent agreements upon written request to the Trustees. Further, such agreements are available for examination at the Trust Fund Office, and at local union offices, upon ten days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. You may wish to inquire as to the amount of the charge before requesting copies.

ELIGIBILITY FOR PLAN PARTICIPATION

The eligibility rules that determine when You and Your dependents are entitled to benefits are described in the Eligibility and Enrollment Section of this Summary Plan Description. If at any time You are unable to locate Your Summary Plan Description, an additional copy may be obtained from the Plan Sponsor.

CIRCUMSTANCES RESULTING IN INELIGIBILITY

The eligibility requirements, termination provision and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in the Eligibility and Enrollment and When Coverage Ends Sections of this Summary Plan Description.

SOURCES OF CONTRIBUTIONS TO THE PLAN

The Plan is funded through employer contributions, the amount of which is specified in the underlying collective bargaining agreements (between Participating Employers and labor organizations), and special agreements (between employers and the Board of Trustees for non-collectively bargained employees). Self-payments are permitted under certain circumstances and, in certain circumstances, are required to maintain specified benefits.

PLAN FISCAL YEAR ENDS ON

July 31

CLAIM PROCEDURE

Claim filing and review procedures are described in the Contract and Claims Administration Section of this Summary Plan Description.

HEARING BEFORE BOARD OF TRUSTEES

If after satisfying the Appeal process described in this Summary Plan Description, any participating employee or beneficiary of a participating employee who applies for benefits and is ruled ineligible by the Trustees (or by a committee of Trustees, an administrative agent, insurance carrier, or other organization acting for the Trustees) or who believes they did not receive the full amount of benefits to which they are entitled, or who is otherwise adversely affected by any action of the Trustees, shall have the right to request the Trustees to conduct a hearing in the matter, provided that they make such a request, in writing, within 60 days after being apprised of, or learning of, the action. The Trustees shall then conduct a hearing at which the participating employee or beneficiary shall be entitled to present their position and any evidence in support thereof. The participating employee or beneficiary may be represented at any such hearing by an attorney or by any other representative of their choosing. Thereafter, the Trustees shall issue a written decision affirming, or setting aside the former action. The Trustees have the discretion to interpret and construe all terms of the plan, including the eligibility rules, and will exercise this authority in reviewing a claim appeal.

TERMINATION OF THE PLAN

The Board of Trustees has the authority to terminate the Trust Fund and Plan. As provided in the Trust Fund Agreement, the Trust Fund and Plan will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring payment of contributions to the Trust Fund. As provided in the Trust Fund Agreement, for purposes of these termination rules, a collective bargaining agreement or special agreement covering employees involved in a strike or lockout shall not be deemed to have expired until the strike or lockout has continued for more than six months.

If the Trust Fund and plan terminate, the Board of Trustees will apply the assets remaining in the Trust Fund to pay, or provide for payment, of any and all obligations of the Trust Fund, and will apply any remaining assets in the Trust Fund for the continuation of benefits provided under the Plan until the assets have been exhausted.

NOTICE OF ERISA RIGHTS

As a participant under the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Employer Health Plan Coverage

Continue health care coverage for Yourself, spouse, or children if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or Your Beneficiaries may have to pay for such coverage. Review this Plan Document and the documents governing the Plan for a description of the rules governing Your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

No one, including the Plan Sponsor or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a health and welfare benefit under the Plan or exercising Your rights under ERISA. If Your claim for a health and welfare benefit is denied in whole or in part, You must receive a written explanation of the reasons for the denial. You have the right to have the Plan Sponsor review and reconsider Your claim. Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and You do not receive them within 30 days, You may file suit in the Federal court. In such case, the court may require the Plan Administrator to provide the material and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

Procedures For Filing Claims

If You have a claim for benefits (for Yourself or for one of Your Beneficiaries) which is denied or ignored in whole or in part, You have the right to a hearing before the Plan Sponsor at which You may present Your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of Your choice. Further, if You are dissatisfied with the Plan Sponsor's determination, You may pursue an action pursuant to 29 USC§1132(a).

For detailed information on how to submit a claim for benefits or how to file an appeal on a processed claim, refer to the Submission Of Claims and Reimbursement and Appeals provisions of this Plan Summary Plan Description.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the US Department of Labor, or You may file suit in Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administration Office:

Welfare and Pension Administration Service, Inc.

Street Address:
7525 SE 24th Avenue Suite 200
Mercer Island, WA 98040

Correspondence Address:
PO Box 34203
Seattle, Washington 98124

1 (206) 441-7574

Claims Administrator:

Regence BlueShield
1111 Lake Washington Blvd N., Suite 900
Renton, WA 98056

1 (866) 240-9580
regence.com

This plan arranged by:

Marcus Morrell
Brown & Brown of Washington, Inc.

Gail McGinn
Gail E. McGinn Insurance, Inc.

Regence

2024 SUMMARY PLAN DESCRIPTION FOR:

MACHINISTS HEALTH AND WELFARE TRUST FUND

Group Number: 10009613

Plan 13 Vision Benefits

Regence

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

Introduction

NOTE: THIS SUMMARY PLAN DESCRIPTION PROVIDES VISION BENEFITS ONLY.

Welcome to participation in the self-funded group vision plan (hereafter referred to as "Plan") provided for You by the Machinists Health and Welfare Trust Fund. The Machinists Health and Welfare Trust Fund has chosen Regence BlueShield to administer claims for the Plan. Throughout this Summary Plan Description, the Machinists Health and Welfare Trust Fund may be referred to as the "Plan Sponsor."

TRUST PAID BENEFITS

The Plan is administered by Regence BlueShield (usually referred to as the "Claims Administrator" in this Summary Plan Description). This means that the Machinists Health and Welfare Trust Fund, not Regence BlueShield, pays for Your covered vision services and supplies. Your claims will be paid only after the Machinists Health and Welfare Trust Fund provides Regence BlueShield with the funds to pay Your benefits and pay all other charges due under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Because of their extensive experience and reputation of service, Regence BlueShield, in collaboration with Vision Service Plan (VSP), has been chosen as the Claims Administrator of the Plan.

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description is effective August 1, 2024, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueShield and makes it void.

Keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Eligibility and Enrollment, When Coverage Ends and COBRA Continuation of Coverage sections, where applicable, the terms "You" and "Your" mean the Participant only). The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions section or where they are first used, and are designated by the first letter being capitalized.

TO ELIGIBLE PARTICIPANTS:

We are pleased to present You with this new Summary Plan Description which contains the amended and restated Machinists Health and Welfare Trust Fund ("Trust Fund") benefits plan.

We encourage You to read this Summary Plan Description carefully so that You are familiar with Your plan benefits. If You have any questions, please contact the Administration Office at 1 (206) 441-7574.

Board of Trustees
Machinists Health and Welfare Trust Fund

IMPORTANT

No employer or local union, no representative of any employer or local union, and no individual Trustee is authorized to interpret the Plan, nor can any such person act as an agent of the Board of Trustees to guarantee benefit payments. No agreement between an employer and a union may change, override or otherwise affect the Plan in any other way, except as the Board of Trustees may permit by resolution and subsequent revision of the Plan underwritten by the Trust Fund.

The Trust Fund provides benefits to the extent that money is available to continue the Agreement with Regence BlueShield. The Plan is not guaranteed to continue indefinitely. The Board of Trustees may authorize amendments to the Plan, including amendments that affect the eligibility rules and the amount and nature of benefits. Amendments may be made on a prospective basis. The Board of Trustees also has the authority to terminate the Plan at any time according to the terms of the Agreement with Regence BlueShield.

If You have any questions regarding this Plan, You may contact the Administration Office. If You have questions regarding Your benefits, please contact Customer Service at the number below. Telephone contact with the Administration Office does not guarantee eligibility for benefits or benefit payments.

Please keep the Administration Office informed of any change of address, dependent status, or beneficiary designation. All changes as described in the Eligibility and Enrollment Section of this Summary Plan Description should be submitted to the Administration Office on an enrollment form or on subsequent change forms.

The Trust Fund has chosen Regence BlueShield to administer the benefits of this vision plan.

CONTACT INFORMATION

If You have Provider or benefit questions specific to Your vision coverage, call VSP at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday –Saturday 6 a.m. – 5 p.m., Pacific Time. You may also visit VSP's website at **www.vsp.com**.

If You have membership questions, talk with one of the Claims Administrator's Service representatives. Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m., Pacific Time.

Customer Service: 1 (866) 240-9580
(TTY: 711)

Or visit the Claims Administrator's website at: **regence.com.** The Claims Administrator's website also includes a list of contracted health care benefit managers acting on the Claims Administrator's behalf in the utilization of health care services, which can be found at
https://www.regence.com/member/members/member-notices

For assistance in a language other than English, call the Customer Service telephone number.

Using Your Summary Plan Description

ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for vision care or treatment. You control Your out-of-pocket expenses by choosing between "VSP Doctor" and "Out-of-Network Provider."

- **VSP Doctor.** Choosing VSP Doctors saves You the most in Your out-of-pocket expenses. VSP Doctors will not bill You for balances beyond any Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network Provider.** Choosing Out-of-Network Providers means Your out-of-pocket expenses will be higher than choosing a VSP Doctor. Also, an Out-of-Network Provider may bill You for balances beyond any Copayment and/or Coinsurance. This is referred to as balance billing.

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

ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health/vision care planning information, health-related events and innovative health/vision-decision tools, as well as a team dedicated to Your personal vision care needs. You also have access to **regence.com** to help You navigate Your way through treatment decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE PLAN, BUT ARE, NOT INSURANCE.**

- **Go to regence.com.** Use the Claims Administrator's secure website to:
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
  - discover discounts on select items and services*.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE PLAN, BUT ARE NOT INSURANCE.**

Table of Contents

Understanding Your Benefits

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

MAXIMUM BENEFITS

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

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

COPAYMENTS

Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. Refer to the Vision Benefits Section to see what Covered Services are subject to a Copayment.

COINSURANCE (PERCENTAGE YOU PAY)

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

HOW CALENDAR YEAR BENEFITS RENEW

Certain Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

The Agreement is renewed each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar Year.

Vision Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services.

VISION EXAMINATION AND HARDWARE

Provider: VSP Doctor	Provider: Out-of-Network
Payment: You pay $10 Copayment combined for examination and first pair of glasses or contacts during the Frequency Period. The second pair is subject to an additional $10 Copayment. Copayments do not apply for Claimants under age 19.	**Payment:** You pay $10 Copayment combined for examination and first pair of glasses or contacts during the Frequency Period. The second pair is subject to an additional $10 Copayment. Copayments do not apply for Claimants under age 19. In addition to any Copayment(s), You also pay the balance of billed charges at the time of service, which may be reimbursed up to the Out-of-Network Provider limit.
Examination Frequency Period: one examination every Calendar Year	
Hardware Frequency Period: two pairs of glasses (lenses and frames) or one pair of glasses and one supply of contacts every Calendar Year	
Examination limit: $45 for Out-of-Network Provider	
Frame limit for Claimants age 19 and over: $65 for VSP Doctor; $35 for VSP approved wholesale/retail vendor; $70 for Out-of-Network Provider	
Frame limit for Claimants under age 19: $300 for VSP Doctor; $165 for VSP approved wholesale/retail vendor; $70 for Out-of-Network Provider	
Lens limit: VSP Doctor: • $65 elective contacts* for Claimants age 19 and over; • $300 elective contacts* for Claimants under age 19 Out-of-Network Provider: • $30 single vision • $50 lined bifocal or standard progressive lenses • $65 lined trifocal • $100 lenticular • $105 elective contacts* • $210 Necessary Contact Lenses**	

Vision Examination

Professional comprehensive routine eye examination or visual analysis is covered, including:

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

Vision Hardware

Hardware including frames, contacts and lenses is covered, subject to any specified limits. Lenses are limited to standard glass or plastic lenses for one of the following:

- single vision;

- lined bifocal;
- standard progressive;
- lined trifocal;
- lenticular;
- elective contacts*; or
- Necessary Contact Lenses**.

*Elective contact lenses are in lieu of all other frame and lens benefits. When You receive elective contact lenses, You will not be eligible for any frames or other types of lenses again until the next Calendar Year. A VSP Doctor can only submit one claim on Your behalf per Calendar Year. If that claim does not exhaust Your elective contact allowance, then You can pay up front and submit additional claims to VSP until that allowance is exhausted.

**Necessary Contact Lenses are available with a Calendar Year supply if You have a specific condition for which contact lenses provide better visual correction. Necessary Contact Lenses are in lieu of all other frame and lens benefits. When You receive Necessary Contact Lenses, You will not be eligible for any frames or other types of lenses again until the next Calendar Year.

CONTACT LENS EVALUATION AND FITTING EXAMINATION

Provider: VSP Doctor	Provider: Out-of-Network
Payment: You pay $60 Copayment.	**Payment:** You pay 100% of the billed charges; Your payment may be reimbursed up to the Out-of-Network Provider limit.
Frequency Period: one contact lens evaluation and fitting examination every Calendar Year	

Services and supplies for contact lens evaluation and fitting examinations are covered. For an Out-of-Network Provider, the Contact Lens Evaluation and Fitting Examination benefit and elective or Necessary Contact Lenses combined, will not exceed the limit indicated above in the Vision Hardware benefit.

LOW VISION BENEFIT

Low vision benefits for Claimants are covered if vision loss is sufficient enough to prevent reading and performing daily activities. Consult Your Provider for more details and to see if You fall within this category. Covered Services include professional services and ophthalmic materials, subject to any specified limits as explained in the following paragraphs:

Supplemental Examinations (Testing)

Provider: VSP Doctor	Provider: Out-of-Network
Payment: No charge.	**Payment:** You pay 100% of the billed charges; Your payment may be reimbursed up to $125.
Frequency Period: every two Calendar Years	
Limit: $1,000 for up to two Supplemental Examinations (Testing) and Supplemental Aids combined	

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

Supplemental Aids

Provider: VSP Doctor	Provider: Out-of-Network
Payment: You pay 25% of the Allowed Amount.	**Payment:** You pay 100% of the billed charges; Your payment may be reimbursed up to 75% of a VSP Doctor's Allowed Amount.
Frequency Period: every two Calendar Years	
Limit: $1,000 for up to two Supplemental Examinations (Testing) and all Supplemental Aids combined	

Low vision aids, including, but not limited to:

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

DISCOUNTS FROM VSP DOCTORS

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

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

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

Discounts do **not** apply to:

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

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

General Exclusions

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by law.

Certain Contact Lens Expenses

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

Conditions Caused by Active Participation in a War or Insurrection

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

Conditions Incurred in or Aggravated During Performances in the Uniformed Services

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

Corneal Refractive Therapy (CRT)

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

Corrective Vision Treatment of an Experimental Nature

Cosmetic Services and Supplies

Services and supplies for beautification, Cosmetic, or aesthetic purposes.

Expenses Before Coverage Begins or After Coverage Ends

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

Facility Charges

Services and supplies provided in connection with facility services.

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

Additionally, except as required by law for emergency services, government facilities outside the service area are not covered.

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's voluntary participation in an activity where the Claimant 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, the Plan may recover the payment from the person the Plan paid or anyone else who has benefited from it.

Investigational Services
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.

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

- anti-reflective coating;
- color coating;
- mirror coating;
- scratch coating;
- blended lenses;
- Cosmetic lenses;
- laminated lenses;
- oversize lenses;
- premium and custom progressive multifocal lenses;
- photochromic lenses;
- tinted lenses, except Pink #1 and Pink #2; or
- UV (ultraviolet) protected lenses.

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

Motor Vehicle Coverage and Other Insurance Liability
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to the Summary Plan Description.

Non-Direct Patient Care
Non-direct patient care services are not covered, including, but not limited to:

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

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

Personal Items
Items that are primarily for comfort, convenience, Cosmetic, contentment, hygiene, aesthetics or other nontherapeutic purposes.

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

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

Self-Help, Self-Care, Training or Instructional Programs
Except for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-vision self-care and training or instructional programs are not covered.

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 the diagnosis or correction of visual acuity.

Services and/or Supplies Not Described As Covered

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

Travel and Transportation Expenses

Two Pair of Glasses Instead of Bifocals

Work-Related Conditions
Except when a Participant 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 and if You opt out of workers' compensation.

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

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment. However, if You visit an Out-of-Network Provider, You will need to pay the Provider's full fee at the time You receive the service or supply. Additionally, You will need to submit a claim to VSP for reimbursement of Covered Services, minus any Copayment and/or Coinsurance. THERE IS NO ASSURANCE THAT PAYMENT WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR HARDWARE. To get a claim form or to assist in submission of an Out-of-Network Provider claim, You may access Out-of-Network Reimbursement in My Benefits on VSP's website, **www.vsp.com**. Be sure the claim is complete and includes the following information:

- Your name;
- Your date of birth;
- Your address;
- Your identification number;
- the Plan Sponsor's name;
- a copy of the claim receipt from the Provider, including the:
    - Provider's name;
    - Provider's address;
    - date of service;
    - patient's name;
    - patient's date of birth;
    - patient's relation to You; and
    - services performed.

Submit the claim to:

Vision Service Plan
P.O. Box 495918
Cincinnati, OH 45249

Timely Filing of Claims

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

Claim Determinations

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

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

CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your Beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Plan has the right to recover the payment from the person the Plan paid or anyone else who benefited from it, including a provider of services. The Plan's right to

recovery includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any Beneficiaries, even if the mistaken payment was not made on that person's behalf.

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

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

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

Subrogation

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

Reimbursement

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

Constructive Trust

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

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

Assignment
In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have 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.

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

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

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

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health Plan's subrogation and reimbursement interest.

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

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

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

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

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

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

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

Other Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no 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.

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

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

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

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

When This Plan is primary, it determines payment for its benefits first before those of any Other Plan without considering any Other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the same Allowable Expense that this Plan would have paid if it were the Primary Plan. When the Primary Plan is Medicare and This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the Medicare Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for You. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its Maximum Benefit plus any accrued savings.

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

When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the Allowable Expense.

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

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

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

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

Order of Benefit Determination Rules

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

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers You other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the plan that covers You as a dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering You as a dependent, and primary to the plan covering You as other than a dependent (for example, a retired employee), then the order of benefits between the two plans is reversed so that the plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the Other Plan is the Primary Plan.

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

- For a child whose parents are married or are living together, whether or not they have ever been married:
  - The plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
  - If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
- For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree. If benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next contract year;
  - If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
  - If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
  - If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    The plan covering the Custodial Parent, first;

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

    The plan covering the noncustodial parent, third; and then

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

Active Employee or Retired or Laid-off Employee. The plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a dependent of an active employee and You are a dependent of a retired or laid-off employee. If the Other Plan does not

have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

COBRA or State Continuation Coverage. If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law, the plan covering You as an employee, member, subscriber or retiree or covering You as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the Other Plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage. The plan that covered You as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the plan that covered You the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of This Plan or Other Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of this Plan

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

will need to submit Your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

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

Appeal Process

If You or Your Representative wish to seek review of a claim denial or other dispute that is identified below, You may appeal.

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

WHAT YOU MAY APPEAL

You may appeal disputes regarding:

- 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 Claimant and the Plan;
- recission of Your benefit coverage; and
- other matters as specifically required by law or regulation.

Your initial appeal (first-level or expedited) must be pursued within 180 days of Your receipt of the original adverse decision that You are appealing. If You don't appeal within this time period, You will not be able to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum. When Your initial appeal request is received, You will be sent written acknowledgement within 72 hours.

FILING AN APPEAL

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

Method of Request	Contact Information
Secure Online Account	Create an account or complete the form available at **www.vsp.com**
Phone	Call 1 (844) 299-3041 for VSP's Customer Service department Call 1 (800) 428-4833 for hearing impaired customer assistance Customer Service hours: Monday – Saturday, 6 a.m. – 5 p.m., Pacific Time
Mail	Attn: Appeals Department. Vision Service Plan PO Box 2350 Rancho Cordova, CA 95741

INTERNAL APPEAL DETERMINATION TIMING

VSP will send its decision on Your appeal as follows:

Type of Appeal	How and When to Expect a Response
First-level appeal	In writing, within 30 days of VSP’s receipt of the appeal.
Second-level (panel-level) appeal	In writing, within 30 days of VSP’s receipt of the appeal.
Expedited appeal	Verbal notice as soon as possible, but no later than 72 hours of receipt of the appeal, followed by

	written notice within 72 hours of the date of the decision.

FIRST-LEVEL APPEALS

First-level appeals are reviewed by an employee(s) of VSP who was not involved in the adverse decision. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony.

SECOND-LEVEL (PANEL-LEVEL) APPEALS

Second-level appeals must be pursued within 60 days of Your receipt of VSP's decision on the first-level appeal. If You don't appeal within this time period, You will not be able to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum. Second-level appeals are reviewed by an employee(s) of VSP who was not involved in, or subordinate to anyone involved in, the prior decision. You or Your Representative will be given a reasonable opportunity to provide written materials, including written testimony.

EXPEDITED APPEALS

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular appeal process, You or Your Provider may specifically request an expedited appeal. The expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Expedited appeals are reviewed by an employee(s) of VSP who was 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.

DEFINITIONS

The following definitions apply to this Appeal Process Section:

Representative means an individual authorized to represent You for the appeal. A Representative may be:

- Your treating Provider (for expedited appeals, a health care professional with knowledge of Your medical condition is recognized as Your Representative);
- an individual You have identified as Your Representative in a written communication to VSP; or
- an individual identified as Your Representative to VSP Customer Service.

No authorization is required from the parent(s) or legal guardian of a Claimant who is a dependent child and is less than 13 years old.

Eligibility and Enrollment

This Plan is maintained for employees whose employers are required to contribute to the Machinists Health and Welfare Trust Fund pursuant to a collective bargaining agreement between the employer and I.A.M. District Lodge 160, or any other labor organization approved by the Board of Trustees, or by special or non-bargaining agreement. Non-bargaining unit employees may be subject to their employer's probationary periods. In this Summary Plan Description, references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Eligibility and Enrollment and Other Continuation Options sections, the terms "You" and "Your" mean the Participant only).

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents under the eligibility requirements in effect with the Plan Sponsor.

Employees

The Trust Fund maintains a lag month eligibility system. You become eligible to enroll in coverage and maintain eligibility based on that system.

Dependents

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

- The person to whom You are legally married (spouse).
- Your registered domestic partner or domestic partner for whom You have submitted an accurate and complete affidavit of qualifying domestic partnership.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental or physical disability that began before the child's 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
    - the child is a Beneficiary immediately before their 26th birthday; or
    - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as a dependent on either a parent’s or legal guardian’s group coverage since that birthday.

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

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a non-registered domestic partner, an affidavit of qualifying domestic partnership form) to the Claims Administrator. Application for enrollment of a new child by birth, adoption or Placement for Adoption must be made within 60 days of the date of birth, adoption or Placement for Adoption if payment of additional premium is required to provide coverage for the child.

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

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the only time, other than initial eligibility, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form to the Administration Office (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. Such information must be received before enrolling a person as a dependent under the Plan.

When Coverage Ends

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

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

AGREEMENT TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

Termination of Your Employment or You are No Longer Eligible

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

Nonpayment

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

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 Beneficiaries will remain eligible to be enrolled under the Plan 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 newborn 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 make payments for coverage through the Plan Sponsor on time. The provisions described here will not be available if the Plan terminates.

If You and/or Your Beneficiaries elect not to remain enrolled during the leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan 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 Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Beneficiaries) will receive credit for any waiting period served before the leave and You will not have to re-serve any probationary period under the Plan.

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 Plan Sponsor must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by an applicable leave.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

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

Divorce or Annulment

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

Death of the Enrolled Participant

If You die, coverage for Your Beneficiaries ends on the last day of the month following the month in which You are not compensated for 80 hours.

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 the enrolled child exceeds the dependent age limit.
- An enrolled child will also lose eligibility on the date the child is removed from placement if there is a disruption of placement before legal adoption.

OTHER CAUSES OF TERMINATION

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

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional

misrepresentation of material fact or fraud regarding a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan Sponsor), any action allowed by law or contract may be taken, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

COBRA Continuation of Coverage

The following is a brief summary of the continuation of coverage provisions of Federal law, commonly known as COBRA. More detailed information is available from the Administration Office.

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 Beneficiaries (except Your domestic partner and their children) if they lose eligibility because:

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

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

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

General Rules

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

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

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

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

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms described in the Summary Plan Description and claims under the Plan for services provided on and after the date coverage ends will not be paid.

Notice

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

Other Continuation Options

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

Strike, Lockout or Other Labor Dispute

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

You must pay the full cost, including any part usually paid by the Plan Sponsor, directly to the trust that represents You. The trust must continue to pay the Claims Administrator the payments according to the Agreement. This six months of continued coverage is instead of and not in addition to any continuation of coverage provisions of the Plan.

General Provisions and Legal Notices

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

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

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

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

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

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

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

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

Service address. However, notice to the Claims Administrator will not be considered to have been given to and received by the Claims Administrator until physically received.

PLAN SPONSOR IS AGENT

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

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND HEALTH RECORDS

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

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

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

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

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

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

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

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

TAX TREATMENT

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

Definitions

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

Allowed Amount means:

- For VSP Doctors, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers, the billed amount for Covered Services up to any described limit.

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

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

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

Claimant means a Participant or a Beneficiary.

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

Covered Service means those vision-related services, supplies, treatments or accommodations required for the diagnosis or correction of visual acuity. These services must be received from a Physician or optometrist practicing within the scope of their license.

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

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

Frequency Period is the number of Calendar Years, usually one or two, that must pass before benefits renew.

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.

Illness means a:

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

Injury means physical damage to the body caused by:

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

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

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

- 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.
- 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.

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.

Necessary Contact Lenses means contact lenses that are prescribed by Your VSP Doctor or Out-of-Network Provider for other than Cosmetic purposes.

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

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

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

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

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians.

Provider means a Physician, Practitioner or other individual or organization which is duly licensed to provide the services covered under this Plan.

Regence refers to Regence BlueShield.

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.

Summary Plan Description (SPD) is a summary of the benefits provided by the group health plan. A group health plan with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

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

Summary Plan Description

The Plan is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor. Note that the terms "You" and "Your" in this Summary Plan Description Section by and large refer to the Participant.

PLAN NAME
Machinists Health and Welfare Trust Fund

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR
The plan is sponsored and administered by a joint labor-management Board of Trustees, the name and address of which is:

Board of Trustees of the Machinists Health and Welfare Trust Fund
c/o Welfare and Pension Administration Service, Inc.

Street Address:
7525 SE 24th Avenue Suite 200
Mercer Island, WA 98040

Correspondence Address:
PO Box 34203
Seattle, WA 98124

1 (206) 441-7574 or 1 (800) 732-1121

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS
91-1363505

PLAN NUMBER
501

TYPE OF PLAN
Welfare Benefit Plan: vision benefits.

TYPE OF ADMINISTRATION
The Plan is administered by the joint Board of Trustees, with the assistance of Welfare and Pension Administration Service, Inc., a contract administration organization, the address and phone number of which is listed in Plan Sponsor above.

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS
Each member of the joint Board of Trustees is designated as an agent for purposes of accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are set forth below.

Legal process may also be served upon:

Welfare and Pension Administration Service, Inc.

Street Address:
7525 SE 24th Avenue Suite 200
Mercer Island, WA 98040

Correspondence Address:
PO Box 34203
Seattle, WA 98124

1 (206) 441-7574 or 1 (800) 732-1121

NAME, ADDRESS AND PHONE NUMBER OF BOARD OF TRUSTEES

Union Trustees

Arthur Boulton, Chairman
IAM District Lodge 160, Retired
PO Box 1703
Bothell, WA 98041-1703

Beth Burgeon
IAM District Lodge 160
9135 15th Place South
Seattle WA 98108

Zac Collins
IAM District Lodge 160
9135 15th Place South
Seattle WA 98108

Employer Trustees

Mike Wilson, Secretary
United Parcel Service, Inc.
4455 7th Avenue So.
Seattle, WA 98108

Leauri Moore
Canfisco Group
4 Nickerson St.
Suite 400
Seattle, WA 98109

Dale Schiffler
Peter Pan Seafoods
3015 112th Ave NE Suite 100
Bellevue, WA 98004

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to collective bargaining agreements. You may obtain a copy of the pertinent agreements upon written request to the Trustees. Further, such agreements are available for examination at the Trust Fund Office, and at local union offices, upon ten days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. You may wish to inquire as to the amount of the charge before requesting copies.

ELIGIBILITY FOR PLAN PARTICIPATION

The eligibility rules that determine when You and Your dependents are entitled to benefits are described in the Eligibility and Enrollment Section of this Summary Plan Description. If at any time You are unable to locate Your Summary Plan Description, an additional copy may be obtained from the Plan Sponsor.

CIRCUMSTANCES RESULTING IN INELIGIBILITY

The eligibility requirements, termination provision and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in the Eligibility and Enrollment and When Group Coverage Ends Sections of this Summary Plan Description.

SOURCES OF CONTRIBUTIONS TO THE PLAN

The Plan is funded through employer contributions, the amount of which is specified in the underlying collective bargaining agreements (between Participating Employers and labor organizations), and special agreements (between employers and the Board of Trustees for non-collectively bargained employees). Self-payments are permitted under certain circumstances and, in certain circumstances, are required to maintain specified benefits.

PLAN FISCAL YEAR ENDS ON

July 31

CLAIM PROCEDURE

Claim filing and review procedures are described in the Contract and Claims Administration Section of this Summary Plan Description.

HEARING BEFORE BOARD OF TRUSTEES

If after satisfying the Appeal process described in this Summary Plan Description, any participating employee or beneficiary of a participating employee who applies for benefits and is ruled ineligible by the Trustees (or by a committee of Trustees, an administrative agent, insurance carrier, or other organization acting for the Trustees) or who believes he or she did not receive the full amount of benefits to which he or she is entitled, or who is otherwise adversely affected by any action of the Trustees, shall have the right to request the Trustees to conduct a hearing in the matter, provided that he or she makes such a request, in writing, within 60 days after being apprised of, or learning of, the action. The Trustees shall then conduct a hearing at which the participating employee or beneficiary shall be entitled to present his or her position and any evidence in support thereof. The participating employee or beneficiary may be represented at any such hearing by an attorney or by any other representative of his choosing. Thereafter, the Trustees shall issue a written decision affirming, or setting aside the former action. The Trustees have the discretion to interpret and construe all terms of the plan, including the eligibility rules, and will exercise this authority in reviewing a claim appeal.

TERMINATION OF THE PLAN

The Board of Trustees has the authority to terminate the Trust Fund and Plan. As provided in the Trust Fund Agreement, the Trust Fund and Plan will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring payment of contributions to the Trust Fund. As provided in the Trust Fund Agreement, for purposes of these termination rules, a collective bargaining agreement or special agreement covering employees involved in a strike or lockout shall not be deemed to have expired until the strike or lockout has continued for more than six months.

If the Trust Fund and plan terminate, the Board of Trustees will apply the assets remaining in the Trust Fund to pay, or provide for payment, of any and all obligations of the Trust Fund, and will apply any remaining assets in the Trust Fund for the continuation of benefits provided under the Plan until the assets have been exhausted.

NOTICE OF ERISA RIGHTS

As a participant under the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Employer Health Plan Coverage

Continue health care coverage for Yourself, spouse, or children if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or Your Beneficiaries may have to pay for such coverage. Review this Plan Document and the documents governing the Plan for a description of the rules governing Your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If You have a claim for benefits (for Yourself or for one of Your Beneficiaries) which is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and You do not receive them within 30 days, You may file suit in the Federal court. In such case, the court may require the Plan Administrator to provide the material and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the US Department of Labor, or You may file suit in Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administration Office:

Welfare and Pension Administration Service, Inc.

Street Address:
7525 SE 24th Avenue Suite 200
Mercer Island, WA 98040

Correspondence Address:
PO Box 34203
Seattle, Washington 98124

1 (206) 441-7574

Claims Administrator:

Regence BlueShield
1111 Lake Washington Blvd N., Suite 900
Renton, WA 98056

1 (866) 240-9580
regence.com

This plan arranged by:

Marcus Morrell
Brown & Brown of Washington, Inc.
1 (206) 623-2430

Gail McGinn
Gail E. McGinn Insurance, Inc.
1 (425) 821-6312

Regence